Health Care Financing

Grants and Contracts Report

Investigating Fraud in Hospitals

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Investigating Fraud in Hospitals

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TABLE OF CONTENTS

I. INTRODUCTION

A. The Investigation of a Hospital

The ultimate goal of an investigation of fraudulent practices in the hospital setting is to help ensure the delivery of cost-effective, quality health care through the identification of areas of fiscal abuse and fraud and the prosecution of those responsible. The task of identifying fraudulent activities in a hospital inevitably focuses on reviewing the hospital reports of revenues and expenses to determine if they are complete and accurate. In order to make these determinations, the investigator must understand how hospitals are structured, how they are financed, and how they operate. Furthermore, in this context, the investigator must seek to identify those fraudulent activities that are unique to the hospital as an organizational entity and health service provider, as well as those fraudulent activities in a hospital that are characteristic of other institutions and industries. This distinction is important as fraud involving provider service delivery or fiscal practices to increase reimbursement may be uncovered which would not be found in other kinds of businesses. The identification of fraudulent activities is not easily done, as shall be seen, as there are issues

involving private physicians and their hospital roles, complex hospital accounting and cost reporting, teaching hospital responsibilities, confidentiality of records, physician and hospital departmental contractual relationships within hospitals, as well as variations in patient coverage, reimbursement formulas, and the community served.

This manual is intended for use by the investigator* who has the responsibility to detect and investigate fraud in the hospital setting, particularly with regard to the administration of the Medicare and Medicaid programs, and to gather the proof necessary for a successful criminal prosecution.

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* Investigator, as used in this context, refers to any member of the fraud control unit, including the attorney and auditor and other staff engaged in the collection of data in order to examine the operations of a hospital.

The introduction provides the investigator with an overview of Medicare and Medicaid in terms of eligibility, coverage, and reimbursement; contains a description of the administrative and service structure of a hospital; and describes the mechanism adopted by the government to pay for hospital care on the basis of cost-related reimbursement.**

The main text of this manual details the actual conduct of a fraud investigation and the signals of fraudulent activities that a thorough investigation of the hospital setting may uncover.

The description of the actual conduct of the investigation is divided into two parts. The first part describes the large number of sources of information available to the investigator which may contain evidence of, and leads to fraudulent activities. The second section details specific techniques for detecting, investigating, and proving these fraudulent activities.

The investigation itself will require the talents of the investigator, the accountant, the attorney, and others.

** Cost-related reimbursement means that a hospital is reimbursed based on its costs rather than its charges to patients.

The New York State Medicaid Fraud Control Unit has been organized on the basis of this team concept, and it has been found to be an effective staff organization for purposes of audits and investigations. Each must be able to perform not only his or her own function, but also must be capable of explaining the meaning and relevance of the results of his or her examination to the other staff members and disciplines. No one discipline can be fully responsible for understanding the total hospital structure, organization, and financing; therefore, communication among staff members is critical. Each discipline must be familiar with the areas of concern to the other disciplines in order to carry out its own investigative tasks and advance the development of the overall investigation.

This manual is designed to orient the investigator to a system that has created unique opportunities for fraud. The ultimate victim, the taxpayer, is often ignorant of these opportunities, and with no individual victim to point the way, the investigator must be equipped with an understanding of Medicare and Medicaid and the hospital industry. The eye must be trained with the "night vision" that will lead from the effect to the cause.

This manual is the necessary preparation.

B. Program Legislation and Coverage

In 1965, the Social Security Act was amended to include Title XVIII (42 U.S.C. §1395 et seq.) which established Medicare, a program of health insurance administered by the federal government. Medicare provides coverage to all persons 65 years of age and over regardless of income. Eligibility for Medicare benefits has since been broadened to include disabled persons and individuals suffering from end-stage renal disease. Since 1975, persons who have not made the required contributions to the Social Security system are nevertheless entitled to enroll in the program for a monthly premium.

Financed through the Social Security system, Medicare is composed of two interlocking parts: Part A, hospital insurance, and Part B, medical insurance. Part A is often termed "compulsory" health insurance as those who pay social security contributions during their working lifetimes cannot opt out of the program, although they can decline to accept its benefits. Part A helps to pay for medically necessary inpatient hospital care, post-hospital extended care services and post-hospital home health services. Part B is funded through monthly contributions made at the election of the insured upon

becoming eligible (e.g., attaining age 65), and helps to pay for medically necessary physicians' services, outpatient hospital services, outpatient physical therapy and speech pathology services, as well as some medical services and supplies not covered by Part A, and home health services not preceded by hospitalization. The Medicare program involves deductibles and co-insurance, that is, payments for services furnished during any spell of illness are reduced by the applicable deductible and co-insurance amounts. Benefits are administered for Part A by fiscal intermediaries and for Part B by insurance carriers.

In the same legislative package with Title XVIII, Congress enacted Title XIX, Medicaid (42 U.S.C. §1396 et seq.). Medicaid is premised on public assistance to the needy with a concept of medical indigency built in. Medicaid is, therefore, available to persons meeting income eligibility, including those eligible for public assistance and those whose medical expenses result in their spending down to a level of medical indigence. In general, Medicaid pays for hospital and medical services for persons too poor to pay for them.

Medicaid is state and locally administered with at least one-half of the costs assumed by the federal government,

and the remainder split between the state and local governments. Rates for services provided by institutions and facilities are established at the state level. Program eligibility requirements and types and amounts of services provided vary from state to state. Some states cover only the "categorically needy" and others provide coverage as well for the "medically needy" who must spend down to a certain income level in order to receive benefits. In general, the "categorically needy" are persons who are receiving public assistance, because they are poor and are either aged, blind, disabled, or specified members of families with dependent children; the "medically needy" are persons who could qualify for public assistance except for their slightly greater income or resources, but lack sufficient income or resources to pay all their medical bills.

Administratively, Title XIX (Medicaid) required each state to submit a state plan for medical assistance to the Department of Health, Education, and Welfare ("HEW"). Each state had to designate a single state agency to administer the plan and had to meet other requirements. Having met the requirements for eligibility and services, among others, and having produced a document describing the program in detail,

the state can obtain a substantial subsidy from the federal government for its Medicaid program. The minimum federal contribution for medical assistance expenditures to a state's approved Medicaid program is 50%, with a maximum of 83%, based on a complicated formula where the federal contibution varies inversely with the per capita income of the state, that is, the federal government pays most to the state with the lowest per capita income. The federal government will also pay 75% of the administrative costs attributable to skilled professional medical personnel and 50% of other administrative costs in the state. Federal payments are made by HEW based upon quarterly estimates furnished by the state.

Under Title XIX (Medicaid), all categorically needy persons covered by a state plan must be provided with five basic services: (1) inpatient hospital services (other than in an institution for tuberculosis or mental diseases); (2) outpatient hospital services; (3) laboratory and X-ray services; (4) skilled nursing home services for persons aged 21 and older (other than in an institution for tuberculosis or mental diseases); and (5) physicians' services when given in hospital, office or elsewhere. If the state plan includes the medically needy, at least the following items of medical and

remedial care and services must be provided to these persons: either the five basic services described above or any seven of sixteen services, the five basic ones plus eleven enumerated services: (1) medical or remedial care or services other than physicians' services; (2) home health services; (3) private duty nursing services; (4) outpatient clinic services; (5) dental services; (6) physical and occupational therapy, and treatment of speech, hearing and language disorders; (7) prescribed drugs, dentures, prosthetic devices and eyeglasses; (8) diagnostic, screening, preventive and rehabilitative services other than those for which provision is made elsewhere in the regulations; (9) inpatient hospital, skilled nursing facility and intermediate care facility services for persons 65 and over in an institution for tuberculosis or mental diseases; (10) intermediate care facility services other than in an institution for tuberculosis or mental diseases; and (11) inpatient psychiatric services for persons under age 21. The seven optional services may include one or more of the five basic services.

Title XIX (Medicaid) initially did not allow the states to require any cost sharing (enrollment fee, premium, or similar charge, or deductible, co-insurance, co-payment) with recipients for mandatory care and services

provided to categorically needy recipients. States could impose a deductible, co-insurance, or co-payment on the categorically needy for services other than the five mandatory services, and on the medically needy for any service under the state plan, with limitations on the amounts chargeable to recipients. Since 1974, individual states that provide benefits to the medically needy have the option to impose an income-related enrollment fee, premium or similar charge on that class of recipients.

Medicaid is a system of vendor payments, that is, the provider (e.g., hospital, physician, laboratory) files a claim for payment with the state (or local agency) which pays the provider either directly or through a fiscal agent. In some states, the recipient of the services does not have to sign the claim form. Payments to hospitals for inpatient care are on the basis of "reasonable cost", a phrase to be interpreted according to standards approved by the Secretary of HEW. Obviously, "reasonable cost" bears a direct relationship to the actual cost of services provided. Methods of reimbursing other providers of health care are left unspecified. States can, therefore, choose their own reimbursement formula for other than inpatient hospital services provided under Medicaid and set their own

payments schedules, including following the Medicare formula, that is, paying physicians and other eligible professionals their customary charges.

Medicare can be characterized as a highly structured federal program with defined conditions and criteria for eligibility and types of services to be provided, while Medicaid can be characterized as an open-ended program allowing for state discretion. Despite eligibility for Medicare or Medicaid, the patient may nevertheless remain with limited services or coverage. For example, the deductible and co-insurance features of Medicare are a practical limitation on its availability to lower-income, elderly patients because they cannot afford to share costs or purchase supplementary insurance. It is possible, however, under the federal-state "buy-in" agreements for a state to enroll and pay premiums for Part B eligibles receiving public assistance. Further, the failure of physicians to accept assignment for Medicare patients, that is, accept the Medicare determined reimbursement rate in full payment for services, has resulted in patients often having to pay substantial additional expenses. With respect to Medicaid, the low levels of reimbursement have discouraged physicians from delivering services to Medicaid patients in their private offices. Thus, many

Medicaid eligibles with limited access to care use shared health facilities or seek services in costly hospital emergency rooms or outpatient departments.

The Medicare and Medicaid programs are subject to continuous analysis by a variety of governmental units, provider organizations, consumer groups, and other interested parties attempting to define ways to improve and facilitate delivery of health care. With the rising costs of health care, consumer needs for service, and problems in delivery of service, the regulations governing these programs are constantly reviewed and changed. It is important to remain current regarding changes which affect all aspects of these programs, including delivery of service, reimbursement, eligibility, and coverage, as these changes are critical to any investigation of possible fraud.

C. A Cost-Related Reimbursement System

Hospitals are reimbursed under both the Medicare and Medicaid programs on the basis of costs. Not all costs are reimbursable. The general principle is that costs necessary in the efficient delivery of needed health services are reimbursable. Rates for services are determined in a long and complex process on the basis of allowable costs and statistical data. For example, a hospital's inpatient rate is generally determined by dividing allowable costs by the number of patient days reported by the hospital. Rates for services are frequently subject to ceilings established by the regulatory authorities.

The principal sources of hospital revenues are third-party payments--Medicare, Medicaid, Blue Cross, commercial insurance, worker's compensation, no-fault--which account for more than 90% of the direct and indirect payments to hospitals for services provided. The remaining portion of payments is made by persons who have little or no insurance coverage.

Medicare reimburses hospitals on a retrospective cost basis, that is, a hospital submits a cost report after the close of its fiscal year on the basis of which the

hospital is reimbursed for allowable reasonable costs incurred during the year. The cost report and the related report containing statistical data (e.g., patient days, number and types of services) purport to be an accurate breakdown of patient care costs and analysis of the number and types of services delivered. The importance of the cost and statistical reports in the rate setting process makes their preparation a major concern to the hospital, and it is absolutely essential that they be examined in detail in a fraud investigation. For example, the simple device of understating patient days will result in a higher per diem inpatient rate to the hospital.

Since 1974, Medicare reimbursement has been made on the basis of the hospital's customary charges or reasonable costs, whichever is lower. Since actual costs cannot be determined until the end of the hospital's cost reporting period, the fiscal intermediary must establish a basis for interim payments to each provider. An interim rate of reimbursement can be computed and interim payments approximating actual costs will be made throughout the year, with final settlement at the end of the accounting period on the basis of actual (rather than estimated) costs, after audit of the hospital's records and agreement between the hospital and the

fiscal intermediary as to total allowable reimbursable costs. (As noted above, Part A of the Medicare program makes use of fiscal intermediaries for determining and processing claims for payments to hospitals. The fiscal intermediary also has the responsibility to audit the hospitals it services as intermediary to verify the accuracy of the reported cost data.) There is a mechanism for accelerated payments in cases where the hospital is experiencing financial difficulties or delays in submitting bills. The regulations also provide for a periodic interim payment method of reimbursement for Part A hospital and skilled nursing facility inpatient services and Part B home health agency services; under this method, bi-weekly payments approximating costs will be made. Cost reports can be filed with HEW directly or, as is more common, with the fiscal intermediary.

The basis of reimbursement in the Medicaid program is of two general types: reasonable cost, the same as Medicare with certain modifications; or the establishment of payment rates under any alternative method, but no higher than the reimbursement that would be calculated under Medicare. "Reasonable cost" is not defined precisely the same way for both the Medicare and Medicaid programs. The regulations also provide that,

if a third-party payor (including Medicare) has an obligation to pay for health care and services rendered to a Medicaid recipient, the provider is supposed to seek reimbursement from the third-party payor first. Thus, if multiple coverage exists, Medicare has the primary obligation to pay, and Medicaid is the payor of last resort.

Blue Cross is a third--and perhaps the largest--principal source of direct third-party payments to hospitals. Although Blue Cross plans vary widely with respect to the basis for payments (some are based on reasonable costs, others on charges, while others pay on the basis of negotiated prospective rates), Blue Cross plans generally provide for direct payments to hospitals in full settlement of their subscribers' (insured patients') bills. Blue Cross plans throughout the country have agreements with participating hospitals under which payments on behalf of subscribers are made directly to the hospital.

Commercial insurance coverage is another source of third-party payments to hospitals. There are two principal kinds of insurance coverage. An insurer may pay a hospital directly for part or all of covered charges, or the insurer may indemnify the insured

patient for a fixed amount of covered hospital charges.

It should be noted that the Blue Cross Association and a number of commercial insurance carriers act as fiscal intermediaries for Medicare Part A coverage. The Blue Cross Association, as the prime contractor, subcontracts the intermediary role to local Blue Cross plans and provides them with interpretations of the Medicare reimbursement regulations. Part B of the Medicare program makes use of insurance carriers whose primary responsibility is to make payments to doctors. A state Medicaid program may provide all or part of its medical care and services through a fiscal agent which will process and pay vendor claims on behalf of the state.

D. The Hospital: Organization, Services and Administrative Structure

Organization

A hospital can be described as an institution organized principally to provide medical care and services for the prevention, diagnosis, and treatment of disease, pain, injury and other physical and mental conditions. Hospitals fall into three general categories with respect to sponsorship:

(a) Proprietary or investor-owned hospitals. Proprietary hospitals are profit-oriented business corporations or partnerships whose owners are interested in a return on their investment, usually in the form of a periodic income.

(b) Voluntary hospitals. Voluntary hospitals are organized on a not-for-profit basis and comprise roughly one-half of the hospitals in the United States. Voluntary hospitals were originally organized for charitable purposes under the sponsorship of religious groups and other voluntary organizations and associations. The major medical center teaching hospitals and community hospitals are largely organized on a voluntary basis.

(c) Public hospitals. Public hospitals are creations of federal, state and local governments and

are supported in large part by tax revenues. These institutions may serve a specific geographic area or offer a special service and serve a low-income population.

Hospitals are also categorized according to bed size, length of patient stay, and specialized services, e.g., community, teaching, short-term (acute care) and long-term care (more than 50% of patients admitted stay for more than 30 days).

Services

The services provided by hospitals vary widely due to several factors including the type of sponsorship and the community needs of the population the hospital serves. The cost of patient care at each hospital will also vary widely with such factors as the range of services provided, the cost of land, depreciation, labor, food, laundry and linen, equipment, and maintenance and engineering.

Hospital services are delivered on an inpatient or ambulatory service basis, that is, the patient is placed in a hospital bed for a stay on an inpatient basis, or is treated on an outpatient ambulatory basis. Ambulatory

services include emergency, clinic, ambulance, and home health services. There is a wide variety of medical and surgical specialties found in hospitals, such as urology, cardiology, pulmonary diseases, ophthalmology, neurology, obstetrics and gynecology, internal medicine, family services, and pediatrics. Routine care services are regular room, dietary, nursing, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made. Special care units, including coronary care and intensive care units, are also part of routine services. Ancillary services, which also vary in availability, are services for which separate charges are customarily made, such as delivery room, maternity labor room services, operating room, recovery room, anesthesiology, laboratory, blood bank, radiology, pharmacy, and physical, speech and occupational therapy services.

The teaching hospital, as differentiated from the community hospital, has as a basic goal medical education, which involves the teaching of house staff, interns and residents. As such, the teaching hospital offers intensive patient care and extensive specialty, sub-specialty and ancillary services which are not

ordinarily found in non-teaching institutions. In the teaching hospital, an outpatient clinic system is maintained not only to provide care to the community, but also to offer the interns and residents a teaching setting involving direct patient care. The clinics organized in specialty and sub-specialty areas are a phenomenon of medical education and are not ordinarily found in community hospitals or nonteaching facilities.

With the increasing emphasis in health care planning on regionalization of services, there is an attempt at categorizing hospitals as primary, secondary, and tertiary facilities. The intent here is to ensure through planning that there is not a costly duplication of services and equipment in a single geographic area, while at the same time ensuring that basic medical services are available. Basic medical care needs would be met at a primary care facility providing family care services. The secondary facility, such as the community hospital, would have an increased complement of services and equipment for medical care and surgery, but would not have the teaching and research components and intensity of services that characterize the tertiary care faciity. The tertiary level of care would include a variety of specialties and sub-specialties not available at facilities providing lower levels of care.

At this time, however, there is considerable overlapping among the different levels of care and kinds of facilities with respect to services provided to patients. Thus, for example, patients who could be served in primary care family health centers are often treated in teaching hospitals.

Administrative and Service Structure

The hospital administrative and service structure is generally organized along the following lines: patient care services which are usually supervised by a nurse and may include social services and discharge planning; "hotel-type" services such as dietary, housekeeping, laundry and linen services; fiscal and administrative management; and professional services which include services provided by the medical staff as well as ancillary services. Hotel-type services and financial management are usually within the hospital administrator's purview, while professional and patient care services are the responsibility of the medical staff. Although the administrator generally has responsibility for operating ancillary service departments, ancillary services are ordered by physicians. The administrative and service structure varies in part with hospital size, and the separate

service structure components will also vary by category of hospital and range of services provided.

The governing board of a hospital may be called the "board of directors", "board of governors", "board of trustees", or other similar name. The number of persons serving on the governing board will vary with form of sponsorship and size of hospital, among other factors. The governing board of a voluntary hospital will usually include persons who are prominent in the civic and business affairs of the community the hospital serves. The board of a privately owned proprietary institution will usually consist of persons who have an ownership interest in the hospital. The board of a publicly owned proprietary hospital may include employees of the corporation, as well as "outside" directors, that is, persons who are not also employees.

The governing board is responsible for establishing hospital policy and for the overall management of the hospital. Although it may be charged with responsibility for everything that happens in the institution, the governing board does not usually play an active role in management and operation on a day-to-day basis. A large governing board will usually have an executive committee consisting of a small number of

board members that functions as the whole board between regular board meetings. Actions taken by the executive committee should be reported to the whole board which approves or disapproves those actions. A well organized governing board may also have other committees, such as the patient care committee, long-range planning committee, finance committee, professional services committee, and buildings committee to deal with specific areas of the hospital's management and operations. These committees should report to the executive committee, if there is one, and to the whole board.

The administrative structure of a hospital is usually under the direction of a person called the "administrator". The administrator may be known by another name, such as "executive director", "president", or "chief executive officer". The administrator is the agent of the governing board and is the person to whom the board delegates responsibility for the day-to-day operations of the hospital. The administrator may have one or more assistants who have responsibility or authority, or both, over specific areas of the hospital's operations (e.g., purchasing, maintenance).

The governing board also has responsibility for choosing the medical staff. The medical staff has its own

internal administrative organization which varies from hospital to hospital. Medical services are usually divided into departments by physician specialties (e.g., medicine, surgery) each with its own chief. A hospital may also have a medical board made up of the chief of staff, heads of departments and attending physicians with full hospital privileges in a specialty. The medical board may also have an executive committee and other ad hoc committees, as well as professional committees.

II. CONDUCT OF THE INVESTIGATION

When the investigator receives information that a fraudulent act has been committed, his or her task is to develop the evidence that either proves or disproves the allegation. Very often, however, the investigator will receive neither specific nor general allegations. As noted earlier, Medicaid and Medicare fraud have no individual victim, as in the street crime setting, who comes forward to point the investigator to evidence of the crime or to the identity of the wrongdoer. Therefore, the discussion of the conduct of an investigation will begin with the assumption that the investigator has received no specific or general allegation.

A. Preliminary Investigative Steps

The investigator, appreciating the complexity of hospitals, must be prepared to draw upon experienced individuals outside the traditional law enforcement community; these include hospital administrators, physicians, pharmacists, laboratory technicians, public officials, academics, industry associations, and others. Liaison should be established immediately with these persons and organizations, as they may be a source

of information about fraudulent practices in hospitals. There also exist vast amounts of information generated about hospitals by hospitals themselves and by federal, state and local governmental agencies, consumer groups, and other organizations concerned with the delivery and financing of health care. Unfortunately, this morass of information is not organized in a way that readily yields to analysis by the investigator. Information from all these sources serves two valuable functions: to educate the investigator, and to aid in fraud detection and investigation. Therefore, from its inception, the investigative unit must:

(1) Identify the sources of information;

(2) Learn the type and extent of information these sources possess;

(3) Extract what is <u>useful</u>;

(4) Organize the information in a retrievable fashion; and

(5) Maintain liaison with these sources to continue the flow of useful information.

B. <u>Recognizing the Symptoms of Fraud</u>

Useful information will include general and specific allegations developed in interviews and found in documents, as well as other information indicative of fraud. As with a disease, there are signs or signals

which may indicate that fraudulent activity may be the root cause. These can be called "fraud indicators" (signs, signals, occurrences, or existing conditions from which an inference can be made that fraudulent activity might be the cause of, or result of same). These fraud indicators will be apparent from the information developed in the preliminary investigation. These fraud indicators include:

(1) Ineffective Hospital Management. This provides the climate and opportunity for fraud. This includes:

(a) Poor hospital business practices as evidenced, for example, by no structured bidding system in the purchasing area, weak internal control over purchasing and inventory, or premature write-off of bad debts.

(b) Incomplete or inaccurate accounting or medical record retention systems, allowing evidence to disappear or fraud to be concealed. Particular items to seek out are checks and invoices that are missing and medical records that are

incomplete.

(c) Weak internal controls that could be evidenced by a personnel department not under the administrator's jurisdiction, unqualified administrative staff, too many employees acting autonomously, or unsupervised personnel in the business office, and other departments.

(d) Lack of action on prior recommendations made in earlier audits or surveys.

(e) Poor internal controls resulting in one or more persons having too much control over over all aspects (e.g., billing and collecting receivables, writing-off bad debts) of a particular function.

Illustration

The chief bookkeeper/office manager had been employed at a hospital for over twenty years. Her supervisor was the controller who reported directly to the administrator and the executive director. The chief bookkeeper/office manager's responsibilities included supervising the business office and

emergency room bookkeeping staff. She was also responsible for compiling all hospital receipts, insuring that they were properly recorded, and then depositing them in the hospital bank account. She distributed the receipts to the appropriate accounts receivable personnel who were then to record such receipts against their receivables.

The chief bookkeeper/office manager received cafeteria income, X-ray silver reclamation money, medical records receipts, vending machine commissions and laboratory outpatient income which were never recorded in the books and records of the hospital.

This person conspired with the administrator at the executive director's orders to withhold certain receipts from the income records of the facility. This was done from the late 1960's through the middle 1970's. The receipts would be brought to the chief bookkeeper/office manager from certain personnel in the department. The income was not turned over to the personnel required to record such income; thus, assuring non-recording with only her assistant being aware of the unusual situation. This assistant would not question her superior's conduct for fear of loss of employment.

The cash and supporting documents for all miscellaneous income, excluding cafeteria and outpatient lab, were brought to the administrator's office several times a year where accumulations reached between $8,000 and $14,000 per year. This money was held by the administrator. At the end of each year the money was divided into three shares: 25% for the chief bookkeeper/office manager; 50% for the executive director; 25% for the administrator. The chief bookkeeper/ office manager's ability to exercise a decisive role with each of the employees prevented each person from knowing what the other was recording

and enabled the situation to continue.

A comparison of the questionable miscellaneous receipts before the investigation commenced, to the amount of such receipts for the subsequent year, showed a marked obvious difference in the latter year. Intensive interviews of the chief bookkeeper/office manager's subordinates confirmed her unusual handling of such funds and resulted in her eventual involvement as a subject in the investigation.

(2) Questionable Fiscal Practices.

(a) In the billing area, a pattern of sloppy and improper practices like double-billing, billing for services not rendered, overbilling.

(b) A history of numerous disallowances in audits conducted by the intermediary or by the hospital's accountants.

(c) A weakness in the system has been discovered where third-party payments have been made to hospitals exclusively on the basis of bills submitted by the hospital facility, and no check had been made with regard to double billing. Some hospitals bill all third-party

payors who may be providing coverage for the patient and receive payments from more than one insurance carrier. But in many cases, they have retained these monies over an extensive period to improve "cash flow" before refunding the secondary insurance carrier. In one specific instance a hospital obtained duplicate payments and after a period of time transferred them to a separate account and never made the appropriate refund.

(3) Conflict of Interest Settings. For example: A member of the board of directors sold the hospital the land on which the hospital is now located; the administrator is a friend or business associate of a vendor; the personnel director is the son of a board member.

(4) Questionable Vendor Relationships.

(a) Prior investigation of a particular vendor reveals that a vendor gives kickbacks.

(b) A hospital administrator, department head, or similar supervisory person lives way beyond his or her apparent means.

(c) A vendor goes quickly from $10,000 to $100,000 in billings; a residence or box number is shown as the business address.

(d) Significant variations in the costs of hospitals in the same geographic area could be indicative of fraudulent activities.

(5) Ineffective Regulatory Agencies and Fiscal Intermediaries. The overall performance records of such agencies should be considered if:

(a) Some person within these organizations could be susceptible to a bribe.

(b) Their weaknesses could allow opportunities for fraud.

(6) Abusive Medical Practices. This is often signaled by:

(a) Numerous patient or patient advocate complaints, indicating that the

physician is much more concerned with monetary gain than proper medical care.

(b) A hospital owned or controlled by a physician, creating the possibility that the utilization review regulating admissions and medical procedures could be ineffective.

(c) Proximity of the hospital to the doctor's office, with the possibility that the doctor refers a patient back and forth in order to increase billings.

Numerous other specific fraud indicators are identified elsewhere in this manual and the counterpart audit manual.

C. Sources of Information

The following is a listing of the sources that must be checked at the outset of the investigation for information that will be useful to the investigative team.

(1) Allegations. These are complaints received by federal (e.g., HEW Office of Investigations), state, local regulatory

agencies, prosecutors' offices and law enforcement agencies from any person, including former hospital employees and vendors. NEVER ASSUME that a complaint, allegation, or lead developed by another law enforcement or regulatory agency has been investigated or communicated to your investigative unit--or that the other agency is even willing to communicate it to another investigative agency.

(2) Information developed in other investigations. Frequently, there have been investigations or inquiries conducted by special commissions or by legislative bodies during which valuable information has been developed. The minutes (if any) of the proceedings of these investigations and inquiries should be obtained and reviewed, and the persons who conducted the investigations should be de-briefed. Investigations of the practices of an entire industry may have been conducted for another purpose (e.g., determining whether a company or group of companies has engaged in monopolistic pricing or marketing practices)

and the information developed during the course of the investigation may provide valuable leads to the rebate practices of certain vendors. Likewise, a particular vendor, now engaged in hospital business, may have been previously investigated and tried for commercial bribery of an employee in another industry. In short, inquiries should be made to all federal, state, and local agencies within the jurisdiction for substantive information and for leads for further investigation.

(3) Hospital Documents. Cost reports and related statistical reports, documents filed with federal (e.g., HEW), state (e.g., department of health, public health council), and local agencies (e.g., health systems agency) must be examined. (See 4 through 8 below.)

(4) Local Department(s) of Health. A governmental agency charged with regulating matters affecting health in the state. This agency may be established as a separate agency for health (e.g., the New York State Department of Health) or may be a joint

department of health and welfare. The concerns of this department may include the maintenance of public health, prevention of disease, and the safety of the state's residents. As part of its duties, the department may be authorized to license, audit, and review every aspect of health facility planning, construction, and operation in the state. The extent of departmental responsibility for the Medicaid program has to be ascertained in each state as there are variations from state to state. Also, the department charged with regulating health usually maintains agency files on area hospitals. These can provide valuable information concerning the building plans, owners, financial information, and structural organization. This department may issue management assessment reports, conduct medical audits of hospitals, as well as on site inspections. Also, depending upon state organizational structure, boards of licensing and professional misconduct may also have useful information concerning providers of services.

(5) Local Department(s) of Social Services.

A department of social services is usually charged with the administration of public assistance and social service programs in the state and may also be charged with the distribution of Medicaid payments, as it is in New York State. It is important to look at the specific structure of the social services unit in the state as it may be part of a joint health and social services department or a separate unit. A department of social services may also have a fraud detection responsibility.

(6) Local Professional Standards Review Organizations. PSRO is a federally-funded program, organized, administered, and controlled by local physicians (county medical societies), to evaluate the necessity and quality of medical services reimbursable under Medicare, Medicaid, and Title V Maternal and Child Health Programs and Crippled Children's Services. The functions of a PSRO include certification of the necessity, appropriateness and quality of services during a hospital stay, in-depth

review of the quality and administration of health care services, and retrospective review of health services based on patient care data for the development of local norms for hospital utilization. The PSRO in the area should have files on disallowances of patient days and non-reimbursable services, and may be able to provide valuable information concerning provider abuse of the system.

(7) Local Health Systems Agencies. Health Systems Agencies (HSAs) are locally operated planning bodies created under the National Health Planning and Resources Development Act of 1974 (Public Law 93-641). These agencies have as their purpose the improvement of the health of residents of a service area; increasing the accessibility, continuity and quality of health services provided to residents of an area; controlling costs of providing services; and preventing unnecessary duplication of health resources. Functions of an agency in a given area include: certificate of need review for new institutional health services (in an

advisory capacity to the state); gathering and analyzing data on health care resources and utilization; establishing and annually reviewing a health systems and annual implementation plan. The local Health Systems Agencies have boards of directors which participate in the review process and the membership of these boards should be considered in terms of decision making, particularly as those decisions involve expansion of health facilities.

(8) Public Health Councils. A public health council or similar unit may be the designated state health departmental arm or component responsible for the establishment or incorporation of hospitals. This unit may have the authority to approve a certificate of incorporation or application for establishment based on criteria such as: public need for the facility; character, competence and standing of the proposed incorporators, sponsors or operators; and the financial resources of the institution. It is important to identify this unit, its membership, organization, and the activities

within its authority. The Health Systems Agencies (see (7) above) have local area-wide planning and allocation of resource functions, including review of certificate of need for major changes in health care facilities. The state, however, has final authority regarding certificate of need decisions, and the investigative unit should consider the state level decision making process with local Health Systems Agencies.

(9) Medical Societies. These organizations are protective of physicians, but they may provide valuable general information, as well as identify problem areas within their area of operation.

(10) Interns and Residents Groups. They are knowledgeable and should be consulted.

(11) Consumer Groups. There may exist municipal and statewide groups of patient consumers who might have valuable information with reference to abuses and fraud.

(12) Patient Advocates. The state health department or the individual hospital may

have patient advocates who have information concerning patient abuse, unnecessary surgery and other matters that concern health care services and costs.

(13) Fiscal Intermediaries and Fiscal Agents. As noted previously, the fiscal intermediary is the conduit for payments from Medicare to hospitals and has an auditing responsibility. The fiscal intermediary is a prime source and should have a substantial amount of information on the hospitals it audits. A state may have a fiscal agent for the payment of Medicaid funds to providers. Although fiscal agents do not usually have auditing responsibility, they may also be a valuable source of information.

(14) Statistical Systems. There are statistical systems which have detailed information concerning hospital operations and costs, such as Hospital Administrative Services (American Hospital Association) and Professional Activity Study (Committee on Professional and Hospital Activities).

(15) Medicaid Management Information Systems (MMIS). These are computerized processing systems set up by states to process claims for services to Medicaid recipients, to store and retrieve service and payment data for monitoring and analyzing program activity, and to generate management reports. HEW pays 90 percent of the development costs and 75 percent of operating costs after approval of the system.

Interviews with individuals from these agencies and a review of relevant documents will yield information useful to the investigative unit, not only for education and background purposes, but also as an aid in the detection of fraudulent practices.

In addition to existing sources, it may be helpful to supplement the information available by approaching the hospital directly and requesting certain specific information. Experience has shown that many hospitals will provide information on their administrative and service structure, operations, and purchasing practices. A questionnaire (see sample in Appendix A) can be used to gather this information. The investigative unit must allow a lead time for responses

which, experience has shown, may be as much as 90 days from the time of delivery of the questionnaire to submission of responses. Ideally, the questions should cover the five calendar years preceding the year in which the questionnaire is used. There are two principal reasons for going back five years: First, in many states there is a long period between the time the cost report is submitted and the time the rate (based on the cost report) is determined; Second, the investigator can see changes in hospital personnel and vendors during the period. The questionnaire should be directed to the administrator of each hospital. The identity of this person is readily available from the state department responsible for health matters as well as from a directory obtainable from the local or national hospital association. The questions should include the following:

(1) Names and addresses and principal occupations of:

(a) All persons who participate, directly or indirectly, in the ownership or control of the hospital, in the real property on which the hospital is located, or in the entity that manages the hospital.

(b) All members of the governing board, identifying those on the executive committee and special committees.

(2) Names and addresses of:

(a) Administrator and assistants,

(b) Chief financial officer and assistants,

(c) Controller and assistants,

(d) Purchasing agent and assistants,

(e) Independent accountants.

(3) Names and addresses of all vendors of goods and services, including:

(a) Description by category (e.g., food, medical supplies) of goods and services purchased.

(b) Annual dollar volume of purchases.

(c) Amounts of payments received (in cash or in kind) by the hospital or by a designee (e.g., a special purpose fund) of the hospital by way of rebates, contributions, donations, gratuities, commissions, fees, loans, free goods, et cet.

(Note: Because of the volume of purchases, it may be appropriate to suggest that the

hospital limit the information provided to vendors whose annual dollar volume exceeds a specific amount, say $5,000. This limitation will not ordinarily impair the usefulness of the information provided.)

(4) Names and addresses of all independent contractors, consultants, and others rendering services to the hospital with a brief description of the services provided by each and the amounts paid to each. This group includes those who render professional services (legal, collection, accounting, financial, medical, engineering, et cet.); contractors who perform construction work at the hospital; and any other service rendered by a person who is not a full or part-time employee of the hospital.

(5) Description of cooperative buying agreements and arrangements to which the hospital is a party, identifying the cooperative by name and address and furnishing, if available, the names and addresses of other participants.

(6) Description of the hospital's purchasing policies and practices, including details of

bidding, if any, and the names and addresses of persons involved in purchasing, in addition to those identified in the response to item 2(d).

(7) Names and addresses of hospital-based physicians, by department, including:

(a) Description of professional services rendered by each,

(b) Details of the financial arrangements between the hospital and the physicians, including:

(i) Details of any leasing arrangement,

(ii) Details of compensation paid to each physician, describing whether compensation is salary, percentage of revenues (or billings or charges), direct billing, (fee-for-service), or other,

(iii) Details of services (e.g., patient care services, administrative services) for which the physician is compensated, and

(iv) Copies of documentation evidencing financial arrangements.

(8) Percentages, either in terms of revenues or patient days, or both, of hospital costs reimbursed by:
   (a) Medicaid,
   (b) Medicare,
   (c) Blue Cross,
   (d) Other insurance, and
   (e) Self-paying patients.

(9) Description of ancillary (e.g., pharmacy, laboratory, radiology) and outpatient clinical services provided by the hospital.

(10) Description, by general category of books and records maintained on computerized data bank, identifying the system (e.g., IBM 360) used, and any service bureau retained.

To ensure adequate response, it is essential to communicate frequently with the administrator of each hospital in order to speed up the submission of materials.

If computer services are available to the investigative unit, the responses to the questionnaire should be coded,

keypunched, and stored in a data bank by individual hospital. The purpose of this is to allow the investigative unit to retrieve all data submitted by hospitals in a uniform format, and to permit name searches to be made against the files of all hospitals. For example, if an investigator wishes to know the hospitals to which ABC Corp., 47 Fairmont Boulevard, Utopia, Ideal State, sells solutions, both the name and street address can be entered into the data bank to obtain a listing of the hospitals with which the company deals --based on the information furnished by the hospitals. This can be a useful tool in developing leads for investigation.

Another source of obtaining information to be considered by the investigative unit is communication with major hospital vendors and suppliers to request voluntary disclosure of rebate, discount, and buying incentive practices, together with contributions and other types of gifts to hospitals. Experience has shown that many large vendors will comply with such requests, and the investigative unit can use the information furnished to determine if the hospital received and accounted for such items properly. The letter (see sample in Appendix B) making this request should be directed to the chairman of the board, president, or chief executive officer of the

company selected. Requests should be made concerning annual sales to hospitals for the five year period prior to the request. The request should cover all types of payments (including cash, free goods, payments in kind, advances, commissions, fees, loans, rebates, contributions, donations, grants and gratuities), reductions in price (including discounts, allowances, credits, off-invoice pricing, deal pricing), and expenses accounted for by the vendor as advertising, promotion, public relations, research and development and travel and entertainment.

D. Conducting On Site Visits

The presence of the above mentioned fraud indicators or others uncovered during interviews and in reviewing documents does not necessarily mean there is criminal fraud at the hospital. They are signals which require the exercise of common sense and good judgment. If possible, prior to making a decision whether to investigate a hospital, or a component of a hospital, the investigative unit should conduct an on site visit to get first hand knowledge and impressions which cannot be obtained through interviews.

The on site inspection should be made by the investigator, auditor, attorney, and any other appropriate specialists available to the investigative unit. For example, if field information and analysis indicates a suspicion of fraud in the pharmaceutical area, it would be advisable to have a pharmacist accompany the unit.

The advance telephone call from the person in charge of the investigative unit should not only establish the cordial but firm tone of the forthcoming visit, but should also inform the administrator or director which people (e.g., controller, purchasing agent) are to be

present at the meeting and which documents should be available for delivery to the team at the time of the visit. The latter should include, minimally, the hospital's own operating statement, the independent auditor's reports, filled-in organization charts, committees and their members, board of directors and member affiliations.

As soon as possible after the first telephone communication, the investigative unit to be assigned to the hospital should visit it for an evaluation inspection. Their conference with key personnel can provide a wealth of information. During this conference, the investigative team should keep in mind the following key objectives:

--Gather the requested documents.
--Learn the administrative structure of the hospital.
--Evaluate the integrity and competence of the major personnel.
--Explore, develop, and clarify the indicators that brought the unit to the hospital in the first place.
--Identify the weaknesses in internal control.
--Isolate areas of potential fraud.
--Come to know the "character" of the hospital.

Throughout the course of the conference-table interview, notes should be taken. The attorney, auditor, and investigator should all have input into the conference.

Following is a list of matters to be covered during this initial interview:

(1) Obtain organization chart, preferably one that includes the names of the individuals. It is important to establish responsibility, accountability, and chain of command.

(2) Discuss governance of hospital:
   (a) Learn who the members of the governing board are, how they are appointed, their home and business addresses, and occupations.
   (b) Inquire about contracts involving board members, including land deals and construction.
   (c) Ask to review minutes of governing board meetings.
   (d) Inquire into accounts controlled by the board and the role of the principal financial officers. Learn of all segregated accounts.
   (e) Determine the extent of actual management by the board.
   (f) Probe background and qualifications of administrative staff.

(3) Ascertain existing committees and their functions, both administrative and medical. Learn the names of the chairman and members of each committee. If possible, obtain minutes and memoranda of the committees. The Tissue Committee is of particular importance because of its role in the evaluation of surgical procedures; Tissue Committee records may indicate unnecessary surgery, incorrect diagnosis for purposes of billing and other kinds of information pointing to possible fraudulent or abusive practices.

(4) Become familiar with and, if possible, obtain operations manuals of each department. This is particularly important in areas like purchasing, laboratory, and surgery.

(5) Obtain all management letters and accounting reports.

(6) Obtain copies of contracts or documentation evidencing agreements affecting the hospital.

(7) Inquire into ancillary areas such as pathology, radiology, anesthesiology. Their size, structure, equipment and operation should be

learned, and physician financial arrangements with hospital explored (salary, contract, et. cet.). The extent to which independent contractors are used should be disclosed.

(8) Obtain the number, function, and salaries of all in-house physicians and residents. Inquire about nursing and other programs.

(9) Probe into the effectiveness of the PSRO and utilization review committees - whether there has been any reduction in length of stay or surgical procedures.

(10) Ask about problems that currently exist in the hospital from the administrator's point of view, the problems overcome and short and long-range goals.

(11) See if the hospital is unified in purpose or divided. This is particularly noteworthy with regard to the administration and medical staff, nurses and doctors, employees and management. Also inquire about morale and employee turnover.

(12) Determine if any trends can be discerned, if Medicare and Medicaid populations increased, any clinics planned, expansion contemplated, maternity and pediatric cutbacks.

(13) Try to get an overall picture of the type of care provided at the hospital, whether it is general, medical-surgical or specialty (e.g., cosmetic surgery); whether it is a full service, or minimal service hospital. Inquire particularly about specialized equipment, renal dialysis, burn centers.

(14) Admissions and Assignments - Determine who has the ultimate authority for deciding when a patient should be admitted (e.g., resident, house staff, any attending physician, or hospital administrator). Determine who has the ultimate authority to assign a patient to the intensive care unit and move the patient back to the floor. The same applies to discharging patients.

(15) Identify who handles the physician billing. Ascertain whether the hospital has any policy with respect to daily visits, billings, consultation, surgical assistance, et cet.

(16) Medical Records Policy - Determine the hospital's internal policy concerning entering of progress and completion of discharge notes. How soon after examination must they be filled in? What if these policies are not fulfilled? What is the hospital's policy with respect to alteration and falsification of medical records?

(17) Inquire into record retention programs; what records are retained, and how long and where those records are kept.

(18) Request statistical reports, and cost-effectiveness reports.

(19) Inquire about the banks with which the hospital does business.

(20) Check into specific reimbursement ceilings or disallowances.

(21) Determine if the hospital is making or losing money and why.

(22) Learn what internal controls exist, if any, particularly in the financial area, purchasing and computer.

(23) Inquire into the following specific areas:

(a) Accounts receivable and payroll--how are they handled and administered and by whom?

(b) How billing is handled for daily rates, laboratories, radiology, and other ancillary services, and transportation services.

(c) Collection practices - which firms are utilized, why, what is the percentage of bad debts, how much is written off?

(24) Purchasing Area - This should be examined carefully to determine who makes purchases, what policies are established, which departments do their own purchasing. Does the hospital use purchasing cooperatives and what is its attitude toward them? Does the hospital utilize bidding procedures?

(25) Vendors - Who makes decisions to utilize certain vendors, and why? Ask about suspect vendors listed on the questionnaire or books (e.g., advertising agencies) and whether any showed dramatic changes in receivables; look for large accounts, box numbers, et cet. Determine identity

of vendors no longer servicing the hospital and reason for discontinuance. A disgruntled vendor may be a potential source of information.

(26) Ask about miscellaneous sources of income: a gift shop, parking lot, television rentals, vending machines, rent.

(27) Affiliations with the hospital: examine closely affiliations with nursing homes, extended care facilities, apartments and real estate holdings.

(28) Construction and capital plans, architects and vendors. Analyze how decisions were made.

(29) Explore the nature of hospital fund-raising activities and determine controls utilized.

(30) Ask which "perks" are provided to employees, medical and maintenance personnel (e.g., cars, apartments, trips).

(31) Are there any patient representatives or patient advocates on the staff? Who handles the patient abuse allegations?

(32) Request malpractice evaluation reports.

Upon completion of this interview, a tour of the hospital should be undertaken by the investigative unit escorted by key hospital personnel. In particular, observe carefully the condition of the hospital, the patient population, number of empty beds, and employee activity. The tour should include visits to:

	Service Areas	Observations/Purposes
(1)	Outpatient clinics	Number and types of clinics, number of patients, degree of usage, whether patients are being "ping-ponged" from clinic or from emergency room to clinic.
(2)	Emergency Room	How many patients, how many doctors present or on call, the number admitted to the hospital through the ER (this frequently is a means of circumventing the utilization review committee). Ambulance service and staffing should be reviewed.

(3)	Radiology	Manufacturer, type and condition of equipment, as well as types of services provided; what kind of recordkeeping procedure. If possible, speak with radiologist and technician.
(4)	Pathology and other laboratories	Equipment, nature, and number of tests performed. Which tests are sent out and is any outside work brought into the hospital? Recordkeeping.
(5)	Electrocardiology (EKG, which monitors the heart) and Electro-Encephelogram (EEG monitors brain waves)	Equipment type and condition, records check to determine billing practices and numbers of tests performed.
(6)	Operating Room	Equipment. Operating log and schedule.

(7)	Anesthesiology area	Type of facility provided, role of hospital nurse anesthetist, recording procedures.
(8)	Pharmacy	Organization and equipment. Safeguards. Whether unit dosage system is utilized. Disposition of free samples. Inventory control - including controlled substances.
(9)	Typical hospital floor	Equipment, size of rooms, percent occupied, types of patients.
(10)	Intensive Care Unit (ICU) and Cardiac Care Unit (CCU)	Equipment and condition of patients (the condition of the patient warrants the higher reimbursement rate for these units).
(11)	Physical Therapy	Equipment, extent utilized.
(12)	Medical records	Organization of system, completeness of records, retention procedures; competency and training of medical librarian.

(13)	Kitchen	Condition, equipment and cleanliness. Number of personnel and qualifications of the dietitian.
(14)	Cafeteria	Size, volume, condition, quality of management; whether free meals are provided to employees.
(15)	Central supply	Size, amount of material, safeguards. Inventory control.
(16)	Receiving	Location, logging procedures, safeguards for deliveries.
(17)	Maintenance and housekeeping	Controls, size, and competency of staff.
(18)	Laundry	Does the hospital have its own? Are other institutions being serviced there? Size, condition of equipment, number of personnel.
(19)	Security	In-house or retained; size; quality of personnel.

(20)	Gift shop	Organization, activity, amount of revenue generated.
(21)	Auxiliary and voluntary services	Purpose, activities and financial relationship with hospital.

Also tour the accounting office. In addition to observation and note-taking, the tour should include conversations with personnel, so that various procedures performed can be learned and the billing process understood. Frequently, conversations with technicians, medical and accounting staff at one hospital can prove useful in the investigation of another hospital.

Arrangements should be made for the investigative auditing staff to come into the hospital. Be sure that the hospital will allocate space for them and that the necessary documents, papers and records will be available when they arrive, so that the audit can begin without loss of time.

The on site visit plus all previously acquired information now puts the staff of the investigative unit in a position to make an informed decision:

--Should the hospital be audited fully?

--Should an audit be done in one or more specific areas?

--Should the investigative unit withdraw from this particular hospital?

E. Establishing the Permanent File.

Once all the available information has been obtained from the sources referred to above, it must be organized and disseminated in order to be useful to the investigative unit. It is, therefore, essential to establish a permanent file for each hospital under investigation and to deposit into it information and documents in such a manner that they will be available and useful to the entire investigative unit. The file (see Appendix C) should include background data, reports of interviews, audit reports, reports from informants, reports on the progress of the investigation, newspaper articles, and any other information that may have evidentiary value or provide a lead for further investigation.

A central file unit should be established. This unit should have responsibility for the orderly receipt, processing, and control of all mail, complaints, memos, investigators' interview reports, auditors' reports, and related documentary evidence generated during the course of the investigation. To make these items easily retrievable by staff members, a central control or case file should be opened on each hospital under investigation and a file number assigned to it.

Thereafter, all material to be retained and filed should be marked for indexing and classified as follows, if applicable:

(1) Area Code - Regional office primarily responsible for conduct of investigation and prosecutorial jurisdiction.

(2) Classification Code - Denoting category of investigation, e.g., hospital.

(3) File Number - The number assigned to each new case as it is opened.

(4) Serial Number - The number assigned to each new document placed in the case file.

Each document to be filed should be marked for indexing of any pertinent information, such as names of persons, addresses, companies and their addresses, et cet., and a 3 x 5 card prepared and maintained in a central index. This card lists the name, address, and exact document in particular case file where information concerning this person or company is located, such as:

"Johnston, William J., M.D. DN 14-122-32"
145 Adams Street
Denver, Colorado

By examining the central index, a member of the investigative unit can determine if there is any information concerning Dr. Johnston in its files. In

this example, the Denver ("DN") office has a hospital ("14") file on Downtown Hospital ("122") and there is a reference to a Dr. Johnston in the document numbered "32" in that file.

III. TECHNIQUES FOR INVESTIGATING SPECIFIC AREAS OF HOSPITAL OPERATIONS

A. Introduction

At this stage, the investigative unit should possess a general allegation of wrongdoing (e.g., the unit has received an anonymous letter to the effect that the purchasing agent of a certain hospital is known to be taking money from suppliers), or a specific allegation (e.g., the administrator of a certain hospital had an addition built on his residence by Ajax Builders, which, coincidentally, had been awarded a large construction contract a short time before), or one or more of the fraud indicators (see Part II(B)) is present. Based on this information, the investigative unit now has an alleged offense and a possible subject to investigate. In order to conduct an effective investigation, the investigative unit must understand the nature of the hospital operation that is to be investigated and the types of fraudulent activities that may occur there. In the following sections, there is a discussion of the areas in which fraudulent conduct can be detected and the techniques that can be used to develop evidence of such conduct. The schemes summarized are by no means intended to be all-inclusive because the law enforcement

community is well aware of the fact that the kinds of devices and schemes that can be used to defraud the Medicare and Medicaid programs are limited only by the motivation and imagination of the wrongdoer. This discussion shall begin with an examination of vendor schemes, because experience has shown that one of the areas most susceptible to fraudulent activities is the vendor/purchaser relationship.

B. Vendors

In the hospital industry, a supplier of goods or services is most commonly referred to as a "vendor." Vendors may supply items varying in nature from baby food for the newborn, to sophisticated X-ray equipment, and prosthetic devices, as well as various types of services. (Appendix D to this manual is a list of some of the different types of goods and services supplied to a typical hospital by vendors.) Understanding the relationship of vendors to hospitals is key to uncovering fraudulent activities in the purchasing area.

A vendor may have various internal arrangements geared to obtaining and maintaining hospital accounts. For example: (1) salespeople may take orders from the hospital and call them in to their company; (2) front or detailmen may go to the hospitals as "goodwill ambassadors" to demonstrate new products which the hospital then orders directly from the vendor; or (3) bids may be submitted by vendors on a competitive basis with the hospital supposedly responding to the lowest bidder.

Vendors have various methods of compensating their salespeople: flat commission on total sales, commission as a percentage of profits, straight salary, or a combination of several methods. Certain methods may provide an opportunity to hospital employees for illegal gain.

The types of business relationships between vendors and hospitals vary as do the products or services supplied by vendors. Thus, the hospital could (1) purchase directly from a manufacturer, (2) buy through an intermediary, distributor, or supply house, or (3) contract for an entire service through an outside company.

One type of vendor arrangement is the "service contract." This arrangement may take various forms. First, the hospital could contract with a vendor which guarantees to provide a given service or product at a flat contract price. This type of vendor undertakes all responsibility for staffing, supplying, and providing the service. The vendor pays all expenses, salaries, et cet., to operate the service. This allows the hospital to provide a particular service, yet reduces the responsibility for its operation. Second, the hospital might enter into a service contract under which a vendor

could be installed as a manager or supervising consultant at a fixed annual fee. This contract arrangement provides for the vendor to oversee a particular service; however, all raw materials and labor are provided by the hospital and paid by the hospital directly. Under this contract arrangement, the hospital should benefit from the vendor's expertise and the vendor's ability to obtain lower prices on goods by bulk purchasing for this hospital and other hospitals the vendor services.

After examining the initial vendor contract and the hospital's decision to do business with a given vendor, understanding the paper flow generated by the vendor in the hospital is essential work.

In general, the initial document created by the hospital is the purchase order, which is either called in or mailed to the vendor. A written purchase order must bear the signature of either the purchasing agent or another authorized person. The vendor uses the purchase order to prepare an invoice which includes several copies (sales, customer, shipping or packing); that invoice, along with the merchandise, is delivered to the hospital. The hospital's receiving department then verifies and checks the goods against the shipping or

packing list and signs or initials the invoice/shipping or packing list. Subsequently, the invoice is sent to the hospital's business office for payment. In the business office, the bookkeeper verifies that the invoice contains proof of receipt such as the signature of an authorized hospital employee, then verifies price, and records the invoice in the hospital's books.

The above section, together with the following information on vendors, should assist the investigative unit to gather relevant data, analyze that data and then use it to identify and investigate criminal activity as a result of the vendor/hospital relationship. The "paper chase" is as important to the investigator as interviews, informants, surveillance, and other investigative tasks.

Common Vendor Schemes, Scams and Stings

As noted, the schemes a vendor and hospital owner, administrator, or employee can engage in are limited only by the motivation and imagination of the participants. However, the following represent a selection of some of the more common methods by which a hospital or a hospital employee may receive funds to which the hospital and employer are not necessarily

entitled and which may have resulted in Medicare and Medicaid making payments to which the hospital is not entitled.

Kickbacks

A kickback can be defined as anything of value, such as money, gift, or other benefit, which a vendor pays another person in order to obtain or retain the business of that person. Whenever competition for a hospital's business is keen, some vendors may seek an advantage over the competition by offering a kickback to a person at the hospital. On the other hand, an owner, administrator or employee who is responsible for making the selection of vendors may demand a kickback from a vendor as a condition of doing business at the hospital.

This type of scheme can be applied to any vendor which deals with a hospital, but experience indicates it has been most prevalent in the areas of dietary, housekeeping, pharmacy, radiology, maintenance, laundry, and medical supplies. Experience in kickback investigations indicates that kickbacks may range from 2% to 10% of the vendor's sales to the hospital.

A number of interesting schemes to generate kickback money can be created by vendors in cooperation with a hospital employee. A common scheme is the submission of fictitious invoices to the hospital. Fictitious invoices are invoices submitted to the hospital by a vendor where no delivery of goods was in fact made. These invoices appear normal and flow through the regular hospital accounts payable system and result in a hospital check being sent to the vendor. Upon payment of the fictitious invoice, the vendor makes a kickback payment to the hospital employee. In order for the fictitious invoice to be processed at the hospital, one or more hospital employees may be involved, such as chief of the receiving department, purchasing agent, administrator, or even the owner.

The investigator should be aware of the following tell-tale signs (fraud indicators) of the fictitious invoice scheme:

(1) Improbability of the hospital ever using the item invoiced.

(2) Improbability of the hospital ever using the quantity of certain items invoiced (e.g., one investigation revealed that each patient in a

health care facility would have had to be using three washcloths per day at the rate the facility was purportedly ordering them).

(3) The signature of the regular receiving clerk may be missing or forged.

(4) The invoice is dated or numbered out of sequence.

(5) The invoice does not appear to be processed through the usual business office procedure (e.g., absence of spindle holes or stamps).

Illustrations

Illustration #1

A food service manager was employed by the ABC Food Service Company to direct the dietary department at a hospital. This person engaged in the following kickback scheme. Fictitious invoices were made out by a grocery salesman that were consistent with current price and normal quantity of consumption. The food service director signed the invoices which totalled approximately $10,000 for undelivered goods during the period of a year. The false invoices were submitted to and paid by the hospital. The salesman, with the consent and knowledge of the company, was paid about 70% of the fictitious invoices submitted, in checks payable to the

salesman. The checks were cashed and monies totalling about $7,000 were given to the food service manager.

Illustrations #2

A hardware vendor, acting in collusion with the purchasing agent and receiving clerk of a hospital, generated false invoices on non-existent deliveries for over $75,000 worth of maintenance supplies, an amount far in excess of actual anticipated needs. This sum was subsequently divided among the three participants. This scheme between the vendor and purchasing agent could not have been possible without the assistance of the receiving clerk in the maintenance department who signed for receipt of goods never delivered, and also maintained inventory records.

This situation illustrates the importance of separate purchase, receiving and inventory controls, the existence of which would have prevented this scheme from succeeding.

Illustration #3

A hospital dietary manager arranged to purchase merchandise costing approximately $1,000 per month from a meat vendor on condition that the vendor supply him with a phony invoice once a month. This phony invoice was approximately equal to the amount of business that the vendor was doing with the hospital so that in effect it was a 100% kickback. During a three year period this resulted in the dietary manager receiving approximately $30,000 in illegal payments. The dietary manager also insisted that the vendor pay him the amount of the phony invoices up front. After payment, the dietary manager would telephone a fictitious order to the vendor who would make up the phony invoices and submit them along with the legitimate billings to the hospital. The dietary

> manager would then approve all invoices for payment. He circumvented the possibility of being discovered by picking up the merchandise from the meat vendor himself and delivering it to the hospital. In compounding the major kickback, he charged the vendor an additional five percent as a delivery charge.
>
> In order to establish the fraud, investigators obtained copies of the meat vendor's invoices from both the vendor and the hospital. The vendor was interviewed in detail regarding each invoice and, after agreeing to cooperate, he identified to the best of his recollection the phony invoice in each instance. Confronted with such evidence, the dietary manager confessed and was prosecuted.
>
> In those instances in which a vendor is less cooperative or is suspected of operating similar schemes with other facilities, a vendor audit should be considered.

A second scheme used to generate kickback funds is the use of inflated invoices. These are invoices which either (1) overstate the correct price of the goods delivered, or (2) overstate the quantity of goods actually delivered. As with fictitious invoices, the inflated invoices are processed via the normal accounts payable system and a check is written to the order of the vendor. Upon payment, the vendor makes the pre-arranged kickback payment.

The signs of this type of scheme are similar to those outlined above. One major indicator is the existence in the hospital records of a forged, altered, or unsigned

delivery receipt for goods which in fact were never received by the hospital.

Illustration

> ABC Plumbing and Heating Company, at the request of a proprietary hospital owner, submitted inflated invoices in amounts determined by the owner. The new invoices prepared would include the inflated amount plus the original costs of work done by the plumbing firm at the hospital. This invoice would then be submitted to the hospital for payment. The difference between the original invoices which totalled half a million dollars and the inflated invoices was approximately $172,000 over a period of three years. In order to properly account for the inflated invoices, the president of ABC had these submitted by a dummy company set up in the name of his secretary. This was uncovered through interviewing the secretary.

Another scheme used to generate kickback funds is commonly called the straight kickback. This scheme can be joined with either the fictitious or inflated invoice scheme. Here, the kickback is based on a percentage of business done between vendor and hospital. In some instances, an examination of vendor invoices will reveal billings in an average amount of, for example, $1,000 followed sometime later by an invoice of $100. This $100 may be a kickback of 10% of the monthly billings, and most probably is a fictitious invoice.

Illustration

XYZ Supply Corporation was a vendor doing business with a 300 bed proprietary hospital for approximately twenty years. At the time the hospital opened, the owner of the hospital requested XYZ to kickback 5% of each year's total billings. The 5% kickback rate continued until 1971 when the hospital owner's son, who was the purchasing agent at the hospital, demanded an increase in the rate to 10% of all of XYZ's sales to the hospital. Up to this time the owner of the hospital had received the kickback cash directly. When the kickback percentage was changed, the owner's son received the kickback cash. Additionally, the prices XYZ charged the hospital were increased by twice the amount of the rebate with half kept by the vendor. This was uncovered through the interview of the president of XYZ Supply Corporation.

Kickbacks may be uncovered by examining the vendor's records. The vendor may have a separate account in the books on which to draw kickback checks. Usually, the account is labeled "Sales Commission" or "Sales Expense" or given some other innocent looking label. These monies are merely taken from the business and paid to the person taking the kickback. Hence, examination of the vendor's books can be crucial. The investigative unit must be alert to the fact that the vendor may have a separate checking account for the purpose of making illegal payments. Of course, if the vendor has a substantial retail business involving cash sales, detecting this type of kickback from the vendor's books and records will be virtually impossible.

Schemes of the kickback variety also include the vendor setting up a joint charge account for the vendor and hospital personnel in restaurants, stores, and gasoline stations; providing tickets to sporting events; or using other similar devices to pay the personal expenses of a hospital employee.

Illustration

One vendor made his credit card available to a hospital purchasing agent for travel, motels, and restaurants as a form of kickback to continue his business relationship. Another hospital purchasing agent routinely turned over his monthly bills from a major credit card company to a vendor who paid them with company checks.

An area for productive investigation is to conduct background checks on certain hospital personnel to ascertain if he or she is living beyond the means indicated by the employee's compensation. Lastly, interviews with colleagues of the hospital employee may give a hint of jealousy over another's good fortune and lead the investigator to uncovering a kickback arrangement.

Illustration

Illustration #1

The administrator of a hospital was a long

time friend of the owner of the hospital who had been appointed to the position with little or no say from the governing board.

The administrator, a man in his early 40's, lived in a house worth in excess of $200,000. The house had a tennis court, swimming pool, and cabanas and was decorated with fine masonry work. During most of his employment as an administrator, he earned no more than $30,000 per year. During his last year at the hospital he earned $40,000.

The administrator had complete control over hospital operations, reporting his activities only to his owner friend. He acted for his friend as the hospital's liaison with vendors. A percentage of the gross business done by the vendors with the hospital was given to the administrator who acted as the recipient of inflated and fictitious invoices from vendors supplying the hospital with medical supplies, meats, light construction work, electrical, plumbing and heating work. In accepting the fictitious or inflated invoices, the administrator would have them recorded into the books and records of the hospital. After the administrator received the money, it would be placed in a envelope marked for the hospital owner.

Additionally, the administrator stole cash income that was generated by the outpatient laboratory and the cafeteria. He would have all hospital income receipts (i.e. inpatient, emergency room, X-ray, etc.) sent to his office daily for tabulation. Among these were the outpatient and cafeteria receipts. He would then take the cash generated by the outpatient laboratory. Furthermore, he would substitute checks from outpatient with inpatient cash. This enabled him to keep all the currency which would be given to the hospital owner. He advised one of the assistants to lie to auditors by denying that the hospital had an outpatient laboratory.

He asked his assistant if he would be willing to accept "under the table" monies. The administrator paid this assistant hush money of $600 each month.

The administrator's relationship with the hospital owner and the hospital vendors was best evidenced in the transaction of the cafeteria deal. The cafeteria's two principals were told by the hospital owner to pay $300 in cash above the flat rental fee, and the billings for employee meals were to be inflated by $800 per month. Both sums of money were to be turned in to the administrator at the end of each month.

The administrator also received $125 per month (sale of washcloths) as well as $200 per month for hospitality kits sold to the hospital by the hospital owner's relative under the guise that this money would be used by him to pay employee Christmas bonuses.

Location and interview of the administrator's assistant who left the employ of the hospital was the first break in unraveling the administrator's manipulation and provided invaluable leads.

Illustration #2

The assistant director of a major voluntary hospital, disgruntled over his own contract with the hospital, volunteered information concerning the executive director's submission of salary requisitions totalling approximately $50,000 over a period of six years. These were for unused vacation days which were, in fact, actually taken. This allegation was confirmed and corroborated by interviews of support staff and the examination of daily work records, diaries, appointment records and related matter.

As a result of these interviews, further evidence was also uncovered indicating that the executive director had incurred unauthorized expenses against the hospital in the form of vacation trips, purchase of clothing, food and liquor, auto repairs, home improvements, and other personal services.

Sham and Related Corporations.

(1) Sham Corporations.

A small incorporation fee, a mail drop and letterhead are all that are required to create a vehicle for the diversion of substantial sums of money out of the hospital under the guise of legitimate vendor payments. No merchandise is delivered or services rendered, but all the appearances of legitimacy will be present: purchase orders, invoices, correspondence and cancelled checks. The dummy corporation will be one of dozens, if not hundreds, of vendors on the investigator's vendor list. If the amount paid to the sham corporation is small, it may escape the attention of the investigator completely.

Illustrations

Illustration #1

Several sales executives in a newly formed major hospital supply company established a system of utilizing brokers to distribute their merchandise to hospitals. This

system was added to their regular distribution through direct sales by their own salespeople. The sales executives justified the broker arrangement by convincing the company management that these brokers, who were paid a 10% commission, had contacts in the hospital industry and could substantially increase sales volume. The sales executives then set-up their own dummy companies to act as brokers, received the 10% for themselves and kicked back 5% to their hospital employee contacts.

It is significant that this scheme could not have have been uncovered through a regular audit as there was nothing in the hospital records to reflect the broker arrangement. The investigation was developed by interviewing legitimate brokers who were aware of the kickback scheme. From a review of the hospital supply company records, the sham companies were singled out, their bank records were subpoenaed, and payments to hospital employees were identified.

Illustration #2

In another case, investigation revealed that a purchasing agent at a large hospital had been receiving kickbacks from a vendor. In order to increase the volume of sales for the vendor, a new company was formed in which the purchasing agent was made a hidden partner. Needless to say, the sales column increased significantly--as did the kickbacks.

Illustration #3

An assistant director of a large hospital arranged with a small meat vendor to create a fictitious company and process phony invoices for meat and grocery orders through the hospital dietary department. The dietary manager who ordinarily

supervised all food purchases and inventory was coerced by the assistant director into approving phony invoices over a period of four years for non existent food purchases of approximately $100,000. Checks from the hospital were made out to the non-existent company on each invoice submitted and cashed through an account set up in the name of the accomplice vendor. The monies were later divided between the assistant director and vendor. The dietary manager did not share in the proceeds.

The scheme was discovered during the course of a routine audit and investigation of the hospital. The auditors noticed that a certain food vendor had submitted invoices in strict numerical order extending over a period of several years. A subsequent background investigation of the vendor company disclosed that it was not located at the address listed or recorded as a business entity with the county clerk's office. It was also unknown to the wholesale and retail food dealers associations in the area. Examination of the cancelled checks from the hospital to the vendor revealed his identity and the bank in which he had his account. Bank records were subpoenaed and disclosed checks from the vendor to the assistant director of the hospital.

(2) Related Corporations.

The existence of a family relationship between the vendor and the hospital's management, or of an ownership or control interest in the vendor by the hospital's management should have been disclosed on the cost report. The rate computation will reduce the expense to an amount equal to the cost to the vendor of the goods or services provided and the hospital should not be

reimbursed for the amount of profit the related vendor made on the transaction.

(3) Detection of the Sham and Related Corporation. The problem in this area arises when a hospital fails to disclose its dealings with a related company. The investigator is faced with dozens of corporations and partnerships doing business with the hospital. How will the investigator decide which one to examine? As in all such cases, the beginning will be the examination of documents and interviews with employees. Are all the invoices of the company on file at the hospital numbered in close sequential order? (This raises the question of whether or not the vendor has other business and, if not, why not.) Is the address of the company the same as the address of a hospital administrator or near it? Does the same person at the hospital order and receive the merchandise or approve payment? How are checks issued in payment negotiated--who endorses them--at what bank?

The process of learning who owns a business or has an interest in it can be long and complicated. The company can be organized in corporate or partnership form and the numbers of interested parties may increase geometrically as corporation owns partnership and

partnership owns corporation. The logical starting place is the examination of certificates of incorporation and partnership documents, invoices, checks, location of the business, and the banks used. The purpose of the examination will be to find where the connection between the vendor and the hospital is. It could be found simply by discovering that the address of the vendor is the same as the administrator's, or as far removed as the fourth holding company.

Illustrations

Illustration #1

The owner of a hospital set up his own company, MCM Maintenance Corporation, for the purpose of cleaning the hospital. The maintenance company operated for a two month period prior to becoming defunct, but the hospital still continued to disburse approximately $6,000 per month to this corporation and ultimately to the benefit of the owner of the hospital. Inquiry at the hospital revealed that hospital employees cleaned the hospital without outside help.

The same above owner also formed a laundry service company, EZ Linens Corporation, in the names of his two sons. This particular company furnished all the linens to the hospital and provided means of invoicing the hospital for linens never cleaned or sold to the hospital. The above scheme was detected by checks of the total invoiced linens cleaned. This revealed that each patient would have had linens changed six times a day.

Illustration #2

A relative of a principal owner of four nursing homes and two hospitals was employed as president of a textile company until 1969, at which time he became a representative for a food and medical supply vendor using his relationship with his relative as a guarantee of increases sales. He also incorporated XYZ Enterprises and operated as a wholesale distributor of hospital supplies. At the request of the hospital owner, the sales representative obtained a 5% kickback from the vendors he represented that sold to his relative's hospital. At a later point in time, the kickbacks were increased from 5% to 10%. The vendors always paid in cash.

The sales representative, through XYZ Enterprises, submitted padded bills for cleaning chemicals to the hospital. Those bills totalled about $5,000 per month. This amount was then returned to the relative in cash. The laundry received fictitious and padded billings from XYZ Enterprises totalling approximately $60,000 to $70,000 per year. The effect of these practices was that the nursing homes and hospital received greater reimbursement. This was due to the fact that the laundry was a related company, and, therefore, its costs were included with the hospital costs in computation of the reimbursement rate.

XYZ also arranged extra billings for meat to the relative's nursing homes. The billings amounted to an additional $1,200 to $1,300 per month. The meat was marked as received on the billing invoices by forging the signatures of supervisory employees of the relative's nursing homes and hospitals. The sales representative generated cash for the kickbacks to the hospital owners utilizing salespeople who performed no services but received checks and returned the income less 10% for handling. He used a linen vendor to submit phony bills to XYZ, and when they received checks for payment, the cash would be returned with 10% kept by the linen vendor.

XYZ engaged in fictitious billings to both hospitals. Although this company made some deliveries, the sales representative formed a third company which submitted all fictitious invoices totalling more than $90,000.

An extensive investigation of the sales representative's financial background and scrutiny of his many corporations led him to retain counsel. The sales representative with counsel subsequently came forward to cooperate in the investigation. At the same time the vendors who dealt with the sales representative were interviewed and the schemes described were verified and documented.

Rebates

A rebate is generally a cash or credit given by a vendor as a quantity or other discount payable to the hospital. Rebates in and of themselves can be proper business or marketing techniques employed by a vendor. The scheme develops once a properly issued rebate check or cash is presented to the hospital. As with discounts, the hospital is required to offset the discount or rebate against the expense of the specific item which generated the rebate. The ultimate result of this offset is to reduce the cost of a particular item as that cost is ultimately used for reimbursement purposes. Obviously, if a hospital fails to offset the rebate, the hospital benefits both (1) by securing the rebate in hand, and

(2) by reporting an inflated cost for reimbursement purposes. Rebates are made in a wide variety of industries but appear to be especially common in the area of baby formulas, intravenous solutions, and pharmaceutical supplies (where volume discounts are generally given).

Illustration

A leading pharmaceutical firm engaged in the practice of giving promotional rebates to hospitals based on a percentage of the annual sales volume. At the end of each year the firm would prepare rebate checks payable to the hospitals. At one hospital, however, the rebate check was improperly placed in funds for other activities rather than charged as an offset to operating expenses. These checks, after a close examination of the endorsements, revealed that they were used for purposes other than offsets.

A typical rebate system is based on contract, either written or oral. The agreement can take the form of (1) a refund of all or part of the funds expensed by the hospital on an item, or (2) a percentage off the list price. Some vendors prefer giving a rebate to hospitals as opposed to a discount on the face of the invoice as it ties the hospital to the vendor for a definite period of time--six months, one year, or even more. Most large companies that give rebates keep detailed files on the

rebate agreement, calculation, and payment.

Apart from rebates in the hospital supply industry, other services used by the hospital should be examined for rebate or discounting practices, although an industry does not characterize its action in these terms. An example of this is the insurance industry. An investigator should be aware that it may be illegal for an insurance company to give a rebate (other than a dividend) and, therefore, may overlook the possibility of a rebate-like practice at that institution. The investigator must be aware of certain industry practices which are legitimate, however, yet result in the hospital receiving funds from an insurance carrier. The two most frequent ways a hospital can receive funds from an insurance carrier are (1) refund of premium on a cancelled policy, and (2) return of premium based upon experience rated premiums. In certain situations, a hospital can place an insurance policy with a carrier and pay the entire premium at once. Subsequently, the policy may be cancelled and a portion of the premium returned. Hence, on the books of the hospital, the cost of the insurance is not properly reflected, as the return of premium may not have been recorded. Other situations can develop where, due to the nature of the insurance coverage, the premium is based on an experience rated formula. In a given year, if the

hospital's experience rate falls, the hospital is entitled to a return of premium which must be used to offset the insurance cost claimed for reimbursement.

Any scheme regarding the rebate check occurs once the check is delivered to a hospital person who (1) converts the rebate for his or her use, or (2) fails to record the rebate as a reduction in expenses in the hospital's records, or (3) converts and fails to record the offset to expense. Of course, when a rebate is given in the form of a non-cash credit, there is little possibility of diverting funds.

Loans

Vendors may make low-interest or even non-interest bearing loans in order to obtain or retain the business of the institution. A low-interest or non-interest loan made by a vendor to a hospital person is, in the majority of cases, tantamount to a kickback but in this guise it appears legitimate. In actuality, these "loans" are never intended to be repaid, or they contain provisions which result in the cancellation of the loan upon the occurrence of some event, usually the attainment of a certain level of purchases by the hospital. This type of situation is found in the milk

industry where a milk vendor would lend the institution a certain amount of money to purchase or replace refrigerators. In addition, laundry vendors may lend a hospital funds for the purchase of linen. Of course, "loans" can be made to hospital personnel on request, or the vendor's offer, in order to give that vendor preferential treatment in supplying the hospital.

Illustrations

Illustration #1

A contracting firm involved in the manufacture of aluminum and fiberglass awnings and enclosures also did general contracting work for two hospitals, both of which had a physician as the majority owner. The owner of the vendor corporation developed a personal relationship with the hospital owner who prevailed upon the owner of the firm to engage in a scheme whereby the physician loaned approximately $30,000 to the corporation by the issuance of two checks from the hospital. These disbursements were under the guise of phony improvements by the corporation. The physician was eventually repaid by the corporation with vendor checks payable to the physician. The vendor would forge the physician's endorsement and then second endorse the same checks. This was done by the principal of the corporation who would cash such checks and deliver the cash to the doctor.

The firm was requested to do work on the septic tanks at the hospital. The original estimate was for $60,000. However, the final cost was $40,000. The physician advised the firm's owner to bill for $60,000 and to kickback $20,000 to the physician.

Following the interview of the president of the firm, an anyonymous telephone call was received with the information that the firm was destroying its records. Investigators immediately went to the firm's office and secured a voluntary consent to search in the rear section of the plant. They found and removed half charred records. Included in such records were invoices relating to the corporation's dealing with the hospitals under investigation. Attached to the invoices were handwritten documents describing the true disposition of the amounts shown in the invoices which related to the loans and kickbacks.

Illustration #2

In one case, a hospital owner was solicited by a vendor for a loan of $25,000. The owner suggested that the hospital would lend the money to the vendor, if the vendor submitted two fictitious invoices to the hospital in the total amount of $25,000. The vendor did so and the hospital, with the owner's assistance, paid the two fictitious invoices. When the time came to repay the loan, the owner directed the vendor to make ten monthly payments of $2,500 to the owner. In this scheme, all the participants were happy; the vendor got the loan and the owner managed to steal $25,000 from the hospital. Of course, while the hospital was presently out-of-pocket $25,000, that cost was ultimately reimbursed.

Contributions

The hospital may require the vendor to give donations to the hospital's special funds (e.g., a building or education fund) rather than to discount the price or give a rebate. The result is that the hospital will be

reimbursed for more than the actual expense and the vendor will take a charitable deduction on its tax return. A contribution may also be the method by which the hospital administrator may receive a kickback if he or she can employ a charitable institution to serve as a conduit for the money from the vendor (e.g., the vendor makes a contribution by check or cash to Charity A which then passes the money on to the hospital administrator).

Detection of this fraud requires the examination of the vendor's books and the books of the charity. In the latter case, the task is difficult, since charities may not keep adequate books of account.

Vendor Alias

A vendor may own a number of corporations in order to disguise the real party in interest to the transaction. Most hospitals insist that their purchasing departments are above reproach because, as a rule, at least three bids are solicited for each item ordered, and all things being equal, the purchase will be made from the lowest responsible bidder. At first blush, this seems like a situation where there can be no possibility of a kickback. If an analysis of the competing companies is made, however, it may be found that one vendor, in fact,

owns or controls all three of these businesses. This vendor is also paying a kickback, but in order to conceal or cover up these payments, adherence to the three bid rule is simulated. It is fairly common in business to have more than one business owned and operated by the same person or group of persons. For example, one medical supplier operates through a large number of subsidiaries each with a different name; a milk vendor also has been known to operate under five different corporate names.

In uncovering this type of fraud, attention should be paid to the business address of a suspected vendor. Such observations may reveal that a commercial vendor's place of business is in reality in a residential area, or that the vendor's business address is the same as, or in close proximity to a hospital person's residence.

An additional avenue to pursue a vendor investigation is to secure such items as the certificate of incorporation or business certificate of a suspect vendor. These documents may reveal that one of the incorporators of the business is a person at a hospital that uses this vendor. In any suspicious vendor situation, the possibility of ownership or control through relatives should also be explored.

Commissions

Commissions are payments made by a vendor in return for services performed by another and are usually based on a percentage of sales volume. Kickbacks frequently take the form of sales commissions when, in fact, no salesperson brought about the sale. For example, the owner of a hospital, through an intermediary, communicated with principals of four separate dietary vendors and proposed that these vendors supply the hospital. Since the vendor did not incur any commission expense for this lucrative account, the vendor readily acquiesced when the owner requested a cash "commission" equal to 5% of each vendor's sales. Another example is that of a hospital employee who may be influential in having a particular vendor do certain work at the hospital. This vendor may cause a finder's fee to be paid to the employee. This type of fee can take many forms, from a straight kickback to a loan to a consulting fee. Detection of this type of scheme will usually require extensive interviews in addition to an audit of pertinent books and records.

Gratuities and Excessive Gifts

Many vendors give gifts to various members of the hospital staff in appreciation for the business or

assistance given to the vendor throughout the year. These gifts can vary from pens with the vendor's logo, to bottles of perfume or liquor, or even gift certificates or cash. This type of gratuity or gift can be considered to be a part of the normal business custom and practice. A point is reached, however, at which these gifts take on more of the characteristics of a pay-off scheme than a mere friendly gesture. The value at which a gift becomes excessive is a matter of judgment. While a bottle of 12-year old Scotch may be a gift, surely five cases of the same Scotch should be questionable.

In interviewing employees, the investigator should determine whether the hospital generally pays performance, year-end or holiday bonuses. If this practice is followed, the institution should make the bonus payment in the form of a check and reflect the bonus on the employee's W-2 Form for tax purposes. If it is noted, however, that certain employees receive a cash bonus, inquiries as to the reason and the source of the payments should be made. In one hospital investigation, employees receiving cash bonuses in addition to the normal check bonus were aware of a scheme in which the hospital administrator was embezzling hospital funds. The payment of the cash

bonuses was to ensure that these other key employees would not blow the whistle on the administrator.

Renting Space

The scheme in this area involves the rental of hospital space to independent contractors such as coffee and gift shop operators, TV suppliers, and the like. Under the ordinary business arrangement, the hospital would negotiate the rent to be paid by the independent contractor. This rent then becomes a revenue item for the hospital. In this scheme, however, an owner or administrator will negotiate a rent with the independent contractor, but insist that a percentage of the rent be paid by check payable to the hospital's order with the balance to be paid in cash to the owner or administrator. As the concessionaire does primarily a cash business, it is easy to accumulate the cash and make a cash payment.

Illustration

> This scheme occurred in a 300 bed proprietary hospital which rented space to an individual for the operation of a cafeteria. The cafeteria operator agreed to pay a monthly cash kickback of $1,000 to the hospital owner, over and above the stipulated $400 monthly rent received and reported by the hospital. It is

> significant that this low $400 rent was kept at that fixed amount for over 10 years. The $1,000 monthly kickback to the owner was obtained by the cafeteria operator by skimming from the cash receipts.

Rebates In Kind

It is a common practice in the drug and medical supply industry either to give an institution free samples of a particular item or to run promotional sales where for each lot of merchandise purchased, one free lot is delivered.

Short Shipments

In this type of scheme, which involves delivery of less than the amount of goods ordered, a hospital employee who has as his or her main duty the receipt of orders from a vendor intentionally acknowledges full receipt of goods when, in fact, not all of the goods are delivered. Occurrences of this nature include the short-weighting of meat orders, or the short-count of various medical or dietary supplies. Of course, the employee who engages in this type of scheme is compensated by the vendor.

If a hospital has one employee in charge of purchasing and the storeroom, the conditions are conducive for an

employee to remove certain items from the storeroom shelf and sell them to a vendor for cash. Schemes have been uncovered in which the vendor sells the same goods back to the hospital.

Illustrations

Illustration #1

In order to obtain stolen merchandise, a hospital supply salesman made contact with a supply clerk employed at a large voluntary hospital. The supply clerk systematically stole valuable surgical sutures, which are small and easily concealed, and turned them over to the salesman who in turn sold them to his hospital contacts. Ironically, his largest sale was to the unsuspecting purchasing agent of the hospital from which they were stolen.

Illustration #2

The chief receiving clerk had been in charge of the receiving department at a general hospital for many years. His job included receipt of institutional, surgical, and medical supplies. But he had little supervision or control as far as inventory control was concerned. He first became involved in his questionable activities at the hospital when a vendor approached him to accept invoices which showed more items than were actually delivered. The chief receiving clerk took the difference in cash, and for several years was paid approximately $3,600 by the vendor.

The chief receiving clerk had a similar arrangement with an institutional supplier. This situation involved the regular acceptance of invoices that were inaccurate by amounts ranging from $100 to $300. The clerk was paid $10 to $20 per invoice, forty times a year for several years. The hospital was overcharged approximately $5,000.

In a third situation, he was involved with another vendor, a surgical supplier. The vendor purchased supplies from the inventory of the hospital supply room through the receiving supervisor. Over a four year period, the receiving supervisor was paid between $15 and $75 three times a month, 36 times a year. The price paid was 50% of the actual cost of the merchandise. The cash was generated by vendor checks payable to cash.

Substitution of Inferior Goods

A vendor may contract to deliver prime meats to the hospital, but will actually deliver ungraded meat instead. This difference in quality results in a substantial windfall to the vendor. If an employee of the hospital who is responsible for verifying deliveries is aware of this practice, undoubtedly the vendor is paying off that person to keep him or her quiet.

* * *

Vendors - General Information

In the investigation of questionable hospital/vendor dealings, two questions should be resolved as soon as possible: How did the vendor acquire the hospital account, and how does the vendor retain the business?

There are various ways to acquire an account and each has elements that might be fraud indicators. Generally, a salesperson for a vendor communicates with the purchasing agent or individual assigned to ordering of products for the division of the hospital with which the vendor deals. The purchasing agent should attempt to extract the lowest possible price for items needed from the vendor. The vendor generally has a flexible price range to offer to the hospital depending on the individual item, amount being purchased, and date of payment. Where similarly situated hospitals of like size and operation show different prices for the same goods or services, it should be considered a fraud indicator. Once an order is agreed to, the salesperson will send it to the company either with a purchase order from the hospital, or with a company invoice, and the order will be filled and sent to the hospital.

Another method of acquiring business is competitive bidding. Usually, the purchasing agent will call (or write to) a number of vendors and ask them to submit price quotes on a specified date for the required items. On that date, the purchasing agent will open the bids and usually give the order to the lowest bidder. Almost all hospital guidelines allow management to consider prior performance and quality of goods and service in conjunction with price before awarding a contract to the vendor. In this type of purchasing, the hospital generally sets guidelines as to the value of items that must be bid (e.g., sales over $500 in all categories). How bids are solicited, the opening procedure, and the awarding of the contract, are areas that must be scrutinized.

A third method involves large organizations such as a group of voluntary proprietary or public hospitals and is referred to as cooperative or joint purchasing. Where hospitals group together to exert buying influence, all purchases are done on large scale contracts. There is usually some discretion, however, for a purchasing agent to buy limited amounts or types of goods without using the contract purchases, and it is this "off-contract" purchasing that should be examined closely. The structure of the joint purchasing

organization, its financing, and its effectiveness in reducing costs should all be examined.

A fourth basis of vendor contact that must be scrutinized is where a special relationship exists between the vendor and the agent for the hospital. These relationships include the vendor and the hospital employee being related by blood or marriage, the vendor being a former employee of the hospital, the agent for the hospital being a former employee of the vendor, or the vendor being a member of the board or a relative of the member of the board of the hospital. These special relationships must always be considered fraud indicators. As mentioned above, the purchasing agent should normally be looking for the product or service at the lowest available price. The concern with special relationships is that the agent for the hospital, because of the relationship, may not bargain in good faith on behalf of the hospital. These "non-arm's length" relationships are not prohibited, but the investigator must be vigilant and carefully examine these relationships for the existence of inflated and ficticious invoices, kickbacks, overstocking by the hospital, delivery of inferior goods, and other schemes.

C. Hospital Administrative and Service Structure

1. Purchasing Department

Since this department is the cornerstone for most, if not all, of the hospital's ordering, it is an area that should be scrutinized. The purchasing agent is probably one of the key employees of the hospital, one who meets constantly with vendors, and has discretion to deal with whomever he or she pleases.

In investigating the purchasing function, the investigator must examine the flow of paperwork to determine the manner in which orders are placed and filled and deliveries are made. If, for example, the purchase order, after being signed comes back to the purchasing agent's desk with a check attached, the internal control system is weak and the area merits further investigation.

It is important to note the organization of the purchasing department and determine:

(1) Whether it is a separate department.

(2) If the purchasing agent reports to the administrator.

(3) What work and educational experience the purchasing agent has.

(4) Whether there are written policies to establish:

(a) Authority of agent,
(b) Selection of vendors,
(c) Bidding practices,
(d) Quality control, and
(e) Quantity purchases.

If any of these is unclear, a closer examination of the purchasing agent's function should be arrived at by interview with appropriate hospital personnel.

Particular attention should be given to the purchase of furniture and fixtures. Suppliers of these items may have received purchase orders and contracts from hospital personnel by payoff agreements for set cash amounts or percentage of business received and handled through fictitious or inflated invoices. In addition, such a supplier might deliver furniture to the residence of a purchasing agent or other hospital employee in return for being awarded a contract, with the cost being charged to the contract or purchase order.

Hospitals have also been victims of schemes where cost-plus contracts were used to purchase furniture and fixtures, with or without a conspiracy between the vendor and hospital personnel. For example, a vendor contracts to supply furniture and fixtures at cost of $100,000, plus a 6% profit. In reality, the cost was only $75,000, but the vendor obtains blank invoices from the supplier or manufacturer, adds costs totaling $25,000 and submits a bill to the hospital showing total costs of $100,000 plus 6%.

In hospitals where the purchasing agent places orders for pharmaceuticals, the method of sales in this area by the drug companies must be understood. Salespersons for certain pharmaceutical companies are permitted to give free goods. If not properly inventoried by the hospital, these free goods could be sold by the pharmacist over a retail counter in the hospital, if one exists, or to an outside retail pharmacy, and the funds pocketed by the pharmacist or other persons.

Illustration

A purchasing agent received rebates in the form of merchandise from major pharmaceutical companies. He did not enter these goods into hospital inventory and arranged through another cooperative vendor to sell the goods and return the proceeds to him.

Another arrangement involves deal rebates where a salesperson pays the purchasing agent or pharmacist cash, or issues a draft or check for a percentage of the total order placed (e.g., 15% on a $500 order; 10% on a $300 order). The amount of the rebate is, of course, not recorded as a reduction of expense, and may find its way into the pockets of a hospital person.

2. Dietary

Hospitals generally operate their food services in one of two ways: (a) either the hospital maintains its own staff of dietitians, cooks, and service personnel, or (b) the hospital contracts the food service to a company that either runs the dietary department with hospital personnel (in whole or in part), or takes over the food service completely. If the hospital operates the dietary department, it will incur payroll and raw food costs. If a food service operates the dietary department, the service may be provided for a fixed price which includes the vendor's profit, or at cost plus a fixed amount or percentage as profit. The hospital cafeteria and snack bar may be an adjunct of the dietary department, or it may be operated by a service company that may or may not be the same as the service that operates the dietary department.

Substantial amounts of cash may be handled in the cafeteria without adequate accounting safeguards. Pilferage is a significant problem in any food service operation.

The dietary department is usually composed of a dietitian, food service manager, cooks, and other kitchen employees. The primary responsibility of this department is to purchase, cook, and dispense food to all of the hospital patients. Often this department does its own purchasing directly from food vendors and does not deal through the purchasing agent. Therefore, any of the schemes that a purchasing agent can be susceptible to can likewise be true of the individual who makes the purchasing decisions in the dietary department.

Another area to be observed carefully is the dietary department that utilizes an independent food service contractor. In this type of situation, the food service contractor designates vendors for the hospital and an on site food service director, and may even supply personnel who prepare the food. In return, the food service contractor receives a flat fee or per meal charge as compensation. The possibility for unlawful payments is real here. The food service manager could

also be taking kickbacks from the vendors he or she has introduced to the hospitals and then splitting this kickback with other personnel.

The dietary area should be investigated using the same techniques as are employed in the investigation of purchasing.

Illustration

A medium sized voluntary hospital entered into a contract to have its food service department operated by a major food vendor whose on site representative at the hospital would supervise hospital personnel assigned to that department. Shortly after implementation of the service contract, the food service manager gradually expanded his control over the assigned hospital personnel by setting up work assignments, preparing payrolls, and other attendant record-keeping functions. The food service department and its personnel thus became insulated from supervision and control by hospital administration.

With this almost autonomous control, the food service manager ultimately developed a system of presenting the workers' time sheets to the payroll department for the preparation of paychecks. He then arranged to pick up the checks personally and distribute them ostensibly in order to minimize time lost from employees' duties.

As with most hospitals, there is a certain rate of employee turnover and attrition. But the food service manager did not delete such employees from the payroll record as their employment ended; instead, he

carried them as active employees and continued to pick up their checks. He would then forge the former employees' names and negotiate the checks at a bank where he had a friendly bank teller operating in collusion with him. All the while, he continued to forward the union dues under the former employees' names.

Recognizing that there existed no record on the makeup and distribution of the separate vacation checks, the food service manager began submitting duplicate requests for these checks, both for current and past employees. This was possible because of weakness in the fiscal department's organization and operation.

Taking the scheme one step further, he began assigning overtime to the bogus time sheets of former employees. It was these burgeoning costs in the dietary department that initiated inquiry into its operation and resulted in the detection of the fraudulent activities.

3. Linen and Laundry

Because of the expense of maintaining in-house staff and equipment, many hospitals have linen and laundry done on a contract basis by a commercial laundry. Under such as arrangement, the hospital can either purchase its own linens, or the linens can be supplied by the laundry operator. Price and service competition are very keen. Laundry operators use the the same kinds of inducements to obtain and retain business as other vendors. Employee pilferage can also be a problem in this area.

The investigator, in examining the operations of this department, should: (a) determine the arrangements that exist between laundry and the hospital; (b) scrutinize the contractual relationship; (c) determine what inducements were offered and made to secure the contract by the laundry; (d) ascertain whether any loans are payable to the laundry operator; (e) determine whether lost linens have been a serious problem; and (f) review the prices charged for service for fairness and competitiveness.

Other areas of potential fraud involving linen and laundry are the weighing of laundry while wet; including laundry cart in billing weight; and overstating linen shortages. All of these schemes result in overpayment to the vendor and are an indication of possible kickbacks to a hospital employee.

4. Maintenance and Engineering

This department is generally responsible for the efficient and safe operation of services in the building: heat, light, air-conditioning, electric, gas, elevators and escalators, and other machinery and equipment usually found in commercial buildings. This department should also be responsible for repairs

required by ordinary wear and tear and for light construction. Construction of an addition, such as an additional floor, or a substantial improvement will usually be contracted out.

Large amounts of materials and equipment will pass through this department. Tools, hardware, lumber, paint, masonry supplies, and other building supplies, materials, and equipment that are as useful off-premises as they are in the hospital are consumed in this department. Purchasing and inventory controls may be inadequate to prevent waste (e.g., purchasing materials already on hand) and theft.

This department may have a staff of engineers, carpenters, plumbers, and electricians. The size of the staff and the number of trades represented will vary from one hospital to another.

Interviews of employees in this department can be very productive. A hospital administrator may, for example, as a condition of employment, require a carpenter to work on his or her residence during the carpenter's tour of duty, with the result that the regular work will have to be made up by other employees who will probably not be very happy with this arrangement.

5. Physical Plant: The Acquisition and Maintenance of Land and Buildings

The hospital's pre-acquisition negotiations, acquisition of land, and building construction are the chronological steps in the construction of a hospital. Each aspect provides a unique setting and numerous opportunities for fraudulent and other questionable activities.

For a hospital to come into existence, pre-acquisition negotiations for the land have to be undertaken and completed. Once the land is acquired or contracted for, the design, approval, and construction of the buildings are next in the sequence of things to be done. The building having been constructed, it must be filled with the appropriate equipment and both the building and equipment maintained over the period of operation of the hospital. It should be noted that generally the acquisition of land, buildings, fixtures and equipment, and maintenance provide a trail of paper which is often very informative.

In most instances, the logical starting point is the acquisition of the land. The investigator must be aware that inflation of costs is a potential area of illegal activities. The investigator can determine present

record ownership of the land through the county clerk's office in the county in which the hospital is located. Further, an examination of title in the county records will indicate the sequence of ownership of the land prior to the present owner, as well as mortgages, judgments, mechanic's liens, and other encumbrances affecting title. Often, a title search will indicate the cost history of each sale and purchase. Concurrently, as part of this title examination, the investigator should determine if any zoning changes, property evaluations and appraisals have been made, and exactly when those occurred. Any one of these areas can be explored further if the investigator believes it is so warranted. (For example, if zoning changes are suspect, further checks should be made of the zoning board hearings, minutes and interviews and testimony of people who raised objections to the land's rezoning.) Naturally, if the investigator still has suspicions, he or she could also explore the relationship between zoning board members and the ownership/administration of the hospital.

In tracing the land history, the investigator will, of course, observe in most instances a series of mortgage transactions and financial arrangements. Mortgagees (lenders) and mortgagors (borrowers) should be examined

closely. The mortgagee will usually possess closing documents and these can be useful in determining the names of virtually everyone involved in the purchase, the sources of funds paid at the closing, and the fees paid to brokers, attorneys, and others.

If the hospital is located on land that was purchased in separate parcels, it is important for the investigator to determine the chronology and persons involved in the sale and purchase of each individual parcel that makes up the hospital's property.

Another area, which is more likely to be found in the proprietary hospital setting than in any other, is the purchase of income producing property by the hospital for purposes not related to patient care. In this case, the expenses of the property are run through the books of the hospital, but they are not offset by income. (For example, a hospital may purchase an apartment building or a row of houses adjacent to the hospital; such buildings can be put to hospital use as staff quarters or office space; in fact, they may be rented out either to hospital staff, or to others at less than the fair market rate.) Costs such as fuel, maintenance, and mortgage carrying charges will become part of the hospital expenses and will be reflected in the reimbursement rate.

Building

Often, the acquisition and financing of land and buildings are interrelated. A common element in construction, as in land acquisition, is inflation of cost (e.g., the cost of construction in a proprietary hospital can be inflated to increase depreciation). If the general contractor or any of the subcontractors are related to persons involved in the ownership or administration of the hospital, other motives become obvious.

Another motive for the inflation of costs is to provide cash for kickbacks. Knowledge of the construction market in a given area is useful in determining price competitiveness and may provide a clue to the likelihood of kickback arrangements.

Kickbacks do not necessarily flow from the general contractor. They may be disguised as architects' fees, brokerage commissions, finders' fees, attorneys' fees, or some other type of consulting fees. The investigator should examine county records to determine if construction permits for personal residences were requested by hospital personnel during the period of construction. Under these circumstances, the kickback

could be the construction of a new addition, or other improvement (such as a pool) to a structure owned by an owner or employee of the hospital.

Members of the governing board of the hospital should be investigated to determine if any self-dealing has taken place. (For example, was the general contractor or any of the subcontractors really an entity owned or controlled by a member of the governing board? Has the hospital's mortgage been obtained through a board member's bank? Have the insurance premiums been paid to a firm owned or controlled by a board member?) Although there is nothing inherently illegal in self-dealing (although there are usually requirements of disclosure), the investigator should consider such self-dealing as a fraud indicator that warrants further investigation. The awarding of contracts, whether done with or without competitive bidding, should be examined for unusual procedures and the contracts for unusually favorable or questionable terms.

In return for the awarding of a contract for new construction or a major renovation, the contractor may agree to a kickback arrangement with a hospital owner, administrator, member of the governing board, a government official, or any combination of these. As

these contracts are for large sums of money, a kickback can usually be handled without arousing suspicion in the following manner:

(a) Cash payment based on percentage of total contract, paid direct.

(b) Stipulated cash amount, paid direct.

(c) Percentage of architect's fee paid to intended recipient.

(d) Change orders or extra work orders are made during progress of construction to cover cash required.

(e) Contractor performs work on hospital official's residence or other property, or that of a relative, with costs of labor and materials charged to hospital contract.

(f) Hospital offical or relative is carried as a no-show employee. After contract completed, contractor is paid as consultant to hospital for several years, with funds received being paid over to hospital official.

Hospital construction (as all other construction) requires building permits, inspections, and approvals from local authorities, and building department inspectors. In most jurisdictions, preliminary and final blueprints or construction plans (with a list of specifications) must be approved and filed. These plans should be examined to determine whether construction was done pursuant to the plans, and whether inappropriate unreasonable or unusual changes or extras were added and approved during the course of construction. In addition, construction of hospital facilities requires approvals by the local health systems agency and state agency (e.g., public health council).

To summarize, the following steps should be checked by the investigator in examining hospital construction:

(i) Check overall contract--how awarded?

(ii) If bid, did it follow hospital guidelines on bidding procedures?

(iii) Look behind the companies for non-arm's length dealing--was it revealed, or did hospital overpay?

(iv) Conduct searches for construction permits on

homes of key employees or board members during construction period. If any revealed, determine who did the work and how they were paid.

(v) Perform audits of the subcontractors, as well as the general contractor.

(vi) Compare relationships between general contractor and subcontractors.

(vii) Check financing:

(A) Mortgage-local versus foreign bank.

(B) Governmental (e.g., health systems agency, public health council) approvals.

(C) Arm's-length dealings.

(D) Fund raising:

(I) Large contributions,

(II) Donations by contractor.

As a final point in the construction area, the investigator should note that consultation with the auditors is essential if it is determined that an audit of either the general contractor's or subcontractors' books is warranted.

Other documents may be filed which will confirm or contradict expense claims of the hospital. For example, a subcontractor may file a mechanic's lien for a sum considerably less than that claimed by the hospital. The lienor should be interviewed to determine whether the amount claimed in the lien is the full amount due, and whether any money has been received. Property tax records may also provide a means of estimating actual value and, as a result, the extent of any construction.

Department of health records, such as the operating certificate, will set forth how many beds, and what sort of beds have been authorized. The hospital may claim a treatment area that does not exist, or may claim to maintain more beds in a given specialty than actually exist. It is possible that licensing authorities and the reimbursement authorities will not coordinate this information, allowing overbilling to occur.

Construction costs could also involve alteration to the existing structure, as well as additions. The investigator should examine these, keeping in mind that alteration of existing structures requires almost the identical steps and approvals as in new construction, (e.g., acquisition of land, zoning, filing of permits).

Furniture and Fixtures

The land having been purchased and the building erected, major purchases of fixtures and equipment are now made. Generally, a hospital can be considered as a city within itself. It often has everything from emergency electrical generators to automobiles in order to remain self-sufficient. Some of the fixtures and equipment are bought outright, and the purchase orders and contracts and other documentation relating to these items should be examined to determine whether fictitious or inflated invoices exist. Additionally, delivery records and invoices should be checked to determine if any items were delivered to locations other than the hospital (e.g., a sofa sent to an official's residence and billed to the hospital).

Some equipment is not bought outright but leased instead. Kickbacks may be generated as a result of

leasing arrangements. One way is to inflate the cost directly by claiming a monthly rental larger than that which is actually paid, after all adjustments have been made. Additionally, the hospital can lease on paper more items than it actually receives, or lease the items (again on paper) for a longer period than is actually the case. (For example, the hospital may claim to have leased five machines for 40 months each when, in fact, it leased four for a period of 40 months or five for a period of 36 months. Thus, the hospital will generate payments which can be diverted.) Furthermore, equipment may never even reach the hospital. False leases may be generated with the entire rent going to a hospital employee.

As mentioned above, land acquisition, building construction, the purchase of fixtures and equipment, are areas where the investigator and the auditor must be especially careful to maintain constant communication with each other. If a fictitious or falsified invoice is discovered by the auditor, that information should be passed on to the investigator immediately.

6. The Governing Board of Directors and the Administrator

The investigator's interest in the hospital governance will be in direct proportion to its role in the

operation of the hospital. At one end of the spectrum is the board member whose presence on the board is in the nature of an honorarium. This person may attend meetings, but has little more than a prestigious presence to offer to the hospital. As the board member's influence and responsibilities increase, so will the investigator's interest. However, even the most active board member's opportunities for fraud will be limited to one-shot deals (e.g., a decision to refinance by means of a sale and leaseback of hospital equipment might originate and be handled at the board level; similarly, major construction will be decided upon by the board which could arrange financing and selection of builders).

Since most board members will still be active in their own businesses, self-dealing must be watched for (e.g., the chairman of the local bank might see to it that the hospital funds are kept in his bank on non-interest or low-interest bearing accounts).

The day-to-day management of the hospital is handled by the administrator, who will have the opportunity to engage in the whole gamut of illegal transactions from the petty theft of cash to kickbacks, self-dealing, or having personal expenses paid for by the hospital.

Conversely, the board which limits its role to that of policy maker and leaves the daily operation entirely up to the administrator will have little or no contact with the vendors who provide goods and services to the hospital on a day-to-day basis.

Where the board of a voluntary hospital abdicates completely any role in the operation of the hospital, the hospital may in effect be operating as if it were a proprietary hospital owned by the administrator: he or she will set everyone's, including his or her own, salaries, choose all vendors, et cet. In this setting, the administrator's authority is unbridled and he or she could become the main focus of the investigation.

7. Business Office

This section of the administrative structure of a hospital deals with fiscal matters on a day-to-day basis, and includes accounts payable, accounts receivable, billings, collections, payroll, and miscellaneous sources of income. The investigator should determine who the key personnel in this section are, the duties they perform, and the types of internal controls maintained by the hospital to reduce the opportunity for fraudulent activities. Once these key

personnel are identified and their responsibilities determined, an assessment should be made of the strengths and weaknesses of the internal controls. A finding that the business office lacks sufficient internal controls should be considered by the investigator as a fraud indicator.

The potentially fraudulent activities that may be found include:

(a) Employee embezzlement,

(b) Kickbacks,

(c) Improper billing,

(d) No-show employees, and

(e) Theft of hospital property.

In order to establish the existence of any of these schemes, the investigator must determine, among other things:

(i) The controls the hospital has on the handling of cash to ensure that it is not stolen. The

investigator must be aware that income may be diverted from a number of sources, including medical records, gift shop, cafeteria, vending machines, telephone and TV rental, used X-ray film sales, and collections.

(ii) The controls the hospital maintains to ensure that a vendor is not submitting fictitious or inflated invoices or giving kickbacks.

(iii) The inventory controls.

(iv) The controls the hospital maintains to ensure that hospital employees are being paid for work actually performed.

(v) The controls the hospital maintains over payment of business expenses.

(vi) The controls the hospital maintains over patient billing procedures and collection practices.

Business Office - Collection Activities

The hospital should have sound, well-controlled patient billing procedures, as well as follow-up collection

practices involving Medicaid, Medicare, insurance company and private paying patients. There is the potential in these areas for double-billing, embezzlement and kickbacks. The following questions should be answered:

(A) Does the hospital handle its own billing and collection activities? Is outside service or vendor utilized? (Document collection steps used by hospital; how many attempts are made to effect collection before bill is written off as bad debt and referred to collection service.)

(B) Does hospital have follow-up procedures to test if unpaid accounts are truly bad debts, or whether accounts were paid in whole or part and proceeds pocketed by office employee or hospital official?

(C) Has any hospital official a financial interest in the collection service company utilized; are accounts being referred unnecessarily to the company to increase its revenues, usually at one-third or one-half of amount collected; is a portion of collections made being kicked back to a hospital

official?

(D) If a computer service company is doing the hospital billings and it or a related company is also handling collections, is it generating errors in Medicaid or Medicare numbers, patients' street addresses, et cet., which make accounts appear uncollectible, thereafter making simple corrections and effecting collections at heavy cost to the hospital? For example, a billing service company might deliberately send out a former patient's bill to an incorrect address; the mail is returned marked "Unknown at Address"; account is then referred to related collection company who makes collection easily by mailing bill to the patient's correct address.

Illustrations

Illustration #1

The business and financial records of a collection agency were subpoenaed in connection with an investigation into the billing practices of a voluntary hospital. Examination of the agency records disclosed a series of payments over a span of five years to five separate companies

for a total of over $40,000 in "commission" payments. A check of county clerks' records revealed that the principals listed for these companies were, in fact, financial officers in five local voluntary hospitals or persons related to such officers. When confronted with this evidence, the operators of the collection agency, through counsel, agreed to cooperate in the investigation, and detailed a kickback arrangement in which the collection agency paid 5% of its gross fee to the hospital finance officers. The collection agency fee to the hospital averaged 30% of the total amount collected on the outstanding bill, which, over the five year period, amounted to approximately $1,000,000.

It should be noted that a large percentage of the outstanding accounts sent out for collection were easily recoverable in the first instance and should have been handled by the hospital's billing office directly without incurring the 30% collection service fee.

Illustration #2

The following is a description of a fiscal practice involving the patient accounts manager. At the time of any admission to the hospital, the patient is interviewed to determine insurance coverage. Where a patient is covered by more than one insurance carrier, it is the responsibility of the patient accounts manager to communicate the various coverages to all potential third party payors. While coordination of benefits is not a responsibility of the hospital, the proper filing of an insurance claim is.

The patient accounts manager would bill more than one covered insurance claim for a patient's stay. A credit balance (or due to liability) resulted in the accounts of those patients where more than one carrier remitted payment. The excess received in

the patient's account over what was due to the hospital (to settle the hospital bill) was transferred by the patient accounts manager to accounts of other patients where there were open balances still due the hospital.

In this situation, only one of the insurance carriers would be recorded as a receivable in the hospital's records. Other carriers billed would not be reflected on the books until such time as payment would be received. The resulting credit balances in accounts receivable would then be transferred to outstanding patients' accounts.

Investigation that followed revealed that the hospital benefited by $200,000 through this kind of practice.

D. Ancillary, Outpatient and Emergency Services

Ancillary services are usually characterized as those services for which separate charges are customarily made. They are to be distinguished from routine care services (e.g., regular room, nursing, dietary) for which a separate charge is not customarily made. Ancillary services, which vary in availability, include operating room, recovery room, maternity labor room, delivery room, blood bank, radiology, laboratory, pharmacy, anesthesiology, and physical, speech, and occupational therapy. A primary objective of an investigation of ancillary services is to detect improper billing practices such as double billing by hospital and physician, billing for services not rendered, billing for services rendered by someone other than the physician charging for the service, overutilization of services, and other questionable practices.

1. Radiology

A hospital radiology department may provide both diagnostic and therapeutic radiological services, including X-ray films, photofluorographs, X-ray therapy, and therapy involving radium and other

radioactive substances. A hospital may have one or more radiologists on a full or part-time basis who are responsible for directing these services, and the staff should include technicians and aides. In a small hospital, films may be sent to outside radiologists for interpretation. Radiology services may be available in the hospital itself, or in an adjacent clinic, on an inpatient or outpatient basis.

With the rapid development of high technology equipment and the increased utilization of radiological services, radiologists, as hospital-based physicians, have developed complex administrative and financial arrangements with hospitals. Compensation may be salary, percentage of gross charges or billings, salary plus percentage, or the direct billing of patients on a fee-for-service basis. A written description of the arrangement should be on file in the hospital and with the fiscal intermediary. Recently, hospitals have been leasing departments to radiologists who bill patients directly and are responsible for providing services; these physicians will usually assume all the operating costs and may even purchase their own equipment. Radiologists in teaching hospitals are more likely to be on salary than radiologists in community hospitals. Some radiologists service more than one hospital and

have different arrangements with each.

Situations the investigative unit should look for include:

(a) A hospital-based radiologist who also has a private practice may be diverting patients to his or her private office.

(b) The financial arrangements radiologists have with hospitals are frequently so lucrative that there is ample money to be used for kickbacks to hospital personnel.

(c) Used X-ray film is frequently sold as scrap material for the purpose of recovering silver. Used x-ray film developing solution, or sludge, is also sold for its silver content. This results in miscellaneous income that can be diverted by hospital personnel and not recorded as an offset to the department's expense.

Investigative Steps

The investigator should ascertain the following:

(1) Whether department is directed and operated by salaried employees or through contractual arrangement with an outside radiology laboratory. Obtain copy of agreement or other documentation evidencing arrangement.

(2) Whether or not the radiologist has a private practice and what other, if any, medical facilities he or she services.

(3) If department employees are salaried by hospital, radiologist, or both.

(4) If supplies are ordered by the radiology department or central purchasing and what system is used for selecting vendors.

(5) Whether a record is maintained for the disposal of used film and how payment is recorded.

(6) If department employees and supplies are used by radiologist for testing private patients.

(7) If there is evidence of overutilization.

(8) How vendors are selected for expensive X-ray equipment.

(9) If there is any evidence of double billing by hospital and physician. Radiology log and other records should be examined.

2. Laboratory

Clinical and pathology laboratory services provided will vary in complexity and extensiveness with the range of the hospital's services. These services assist the medical staff and may be provided by an independent laboratory under a contractual arrangement, or in the hospital based and staffed laboratory. The laboratory may be under the supervision of either a physician or a laboratory specialist. In instances where the clinical laboratory supervisor is not a physician, he or she is usually directed by a physician, usually a pathologist, who is the director of pathology services for the hospital. It is possible for a pathologist to be both the head of a hospital department of pathology and also be associated with an independent laboratory. The tests provided will include chemistry, microbology, hematology, serology, clinical microscopy, autopsy, histology, and cytology. The appropriate licensing authority should be consulted with respect to the tests that a laboratory can perform, as there may be instances of billing for tests for which the laboratory is not licensed.

The hospital's arrangements for clinical services, particularly those involving independent laboratories, allow for fraudulent and questionable practices such as overbilling, double billing, billing for tests not performed, and kickbacks to physicians who refer patients for tests. These arrangements, the kinds of tests provided, the record keeping and billing procedures, all have to be examined in detail.

Among the areas to be probed by the investigator are those involving billing for laboratory examinations and tests which are performed on automated machines. Often the laboratory will bill as though these tests were performed by hand on an individual basis. This will result in a much higher charge per test. Another area to be investigated is the billing of both patients and third-party payors (i.e., Blue Cross, commercial health insurers, Medicaid and Medicare) and not returning any excess funds received.

Because laboratory service businesses are both profitable and competitive, there may be kickbacks to hospital employees. The method of selecting a laboratory service and the person making this determination will be of prime concern to the investigator. A kickback may take the form of a straight cash payment or some type of free service.

Investigative Steps

(1) Determine if any contractual arrangement between the hospital and an outside laboratory exists. Obtain copy of the contract.

(2) Ascertain how the outside laboratory was selected and whether operators are related in any way to hospital personnel.

(3) Determine what percentage of hospital laboratory work is performed outside of the hospital and identify companies involved.

(4) Determine whether outside laboratories also service the private practice of physicians associated with the hospital.

(5) Determine whether services being performed in outside laboratory can be performed by the facility's own laboratory.

(6) Determine whether prices being charged by facility's outside laboratories are competitive with other laboratories offering comparable service.

(7) Ascertain whether any inducement in the form of kickbacks, rebates, rentals, etc., are paid to the hospital, or its employees.

(8) Ascertain whether hospital laboratory director or other employees have ownership or employment in outside laboratories.

(9) Determine whether purchasing of supplies is done by laboratory employees or by central purchasing department of the facility. Determine the basis for selecting vendors.

(10) Ascertain whether laboratory work unrelated to the hospital is being performed by hospital laboratory personnel utilizing hospital equipment and supplies.

(11) Determine whether unnecessary or duplicated laboratory tests are being performed.

3. Pharmacy

The size and complexity of a hospital's services will determine whether a hospital will have a pharmacy or a drug storeroom only. A hospital pharmacy will be

directed by a registered pharmacist and may have a chief pharmacist, one or more assistant chief pharmacists, staff pharmacists, pharmacy residents, non-professionally trained pharmacy aides, and clerical staff. The pharmacy should have the physical space and equipment for storage, control, preparation, and dispensing of drugs. If the hospital has a drug storeroom rather than a pharmacy, the pharmaceutical services (i.e., compounding and dispensing of prescriptions) will be provided by another hospital with a pharmacy or by local pharmacies; storage and distribution of drugs will be from the hospital drug storeroom. The pharmacy is subject to various health code rules and regulations for storage, control, dispensing and preparation of drugs, especially controlled substances, and the specific policies and procedures employed at a hospital should be documented by the pharmacy and available for review.

Where the hospital has its own pharmacy, it may nevertheless also have arrangements with one or more local pharmacies. These arrangements may exist because the pharmacist may not wish to stock large amounts of seldom used pharmaceuticals. In cases where outside pharmacies are used, there is a possibility that large numbers of prescriptions that could be filled in the

hospital at a lower cost are filled by the outside pharmacy. The outside pharmacy may use brand name drugs in lieu of lower priced generic drugs. A pharmaceutical company can make larger profits from brand name drugs and may arrange a kickback with a hospital pharmacist. The possibility also exists that a pharmacist will pad the pharmacy bill of a patient when the hospital does not detail individual charges. Large pharmaceutical companies often offer incentives to obtain hospital business. These incentives may be free goods and supplies, cash, or rebates. Frequently, the pharmaceutical company will deal directly with the hospital pharmacist. If the incentives are in the form of cash or free goods, they may never be recorded in the hospital's books. The pharmacist may convert the free samples to cash for his or her own use. In those instances where the incentive is in the form of a rebate, it is important to determine that the rebate is shown as a deduction from the operating expenses of the pharmacy department.

Investigative Steps

(1) Determine whether the hospital has its own pharmacy or uses an outside pharmacy. Is there a combination of both?

(2) Ascertain the percentage of pharmacy business done through this arrangement.

(3) Determine whether employees of the pharmacy are salaried, contracted, or a combination of both. Obtain a copy of any contract.

(4) Determine the basis for the selection of the outside pharmacy and whether any relationship exists with a principal owner or operator.

(5) Determine the system of purchasing drugs and supplies for the pharmacy department.

(6) Ascertain the amount of generic drugs used as opposed to brand name drugs.

(7) Determine the procedure for forwarding the pharmacy charges to the billing department. What forms are used? Are copies retained?

(8) Examine major vendor invoices for any indication of rebates or free samples. How were these incentives recorded on the books?

(9) Rebates frequently are supplied separately and do not appear on invoices. Consider a review of vendor's records.

4. Anesthesiology

Hospital policies and procedures governing the administration of anesthesia may be established by the department of anesthesia or, in the absence of such a department, by the department of surgery. Anesthetics may be administered by a qualified anesthesiologist or by a physician anesthetist or a registered nurse anesthetist under the supervision of the operating physician. The compensation of anesthesiologists may be based on a salary, percentage of gross or net billings or charges, salary plus percentage, or direct patient billing on a fee-for-service basis. Usually, the anesthesiologist bills independently. As a result, the anesthesiologist maintains a log or other record as to length of time spent in performing each procedure. This record should agree with the times in the log maintained in the operating room. (In one hospital the secretary to the anesthesiologist routinely added 15 to 30 minutes to the physician's statements for billing purposes.) The anesthesiologist's supplies are usually purchased by the hospital. The anesthesiologist may have input, however,

in the selection of the vendor or the type of equipment and gas ordered. The selection of the anesthesiologist, possible arrangements between the anesthesiologist and vendors, and charges for services not rendered (including charges for stand-by services) are areas for inquiry.

Illustration

In one case, the anesthesiologists properly filled out and signed their time log sheets for patient procedures performed, but they were not listed or approved Medicaid providers. They had another doctor, a Medicaid provider, submit the bills for Medicaid payment with their log sheets attached as supporting documentation. This discrepancy was not noted during the processing for payment, and the bills were paid.

Investigative Steps

(1) Ascertain the financial arrangement between the hospital and anesthesiologist. If contractual, obtain copy of contract. Verify that conditions of contract are being fulfilled.

(2) Ascertain whether employees are salaried by the hospital or the independent anesthesiologist.

(3) Ascertain method of purchasing supplies, whether through central purchasing, by anesthesiology department, or both.

(4) Ascertain identity of other facilities with which anesthesiologist is affiliated.

(5) Ascertain the basis for selection of a particular anesthesiologist.

(6) Ascertain whether the anesthesiologist is actually present during the surgical procedure.

(7) Check anesthesiologist's log against surgery log to verify that time recorded is accurate.

5. Outpatient and Emergency Services

The emergency services of a hospital are usually provided in a unit established for the treatment of those needing immediate medical or surgical care. The unit is usually part of the outpatient department and the patients treated primarily receive immediate medical, dental, or allied services on an unscheduled basis. The emergency outpatient may be treated in the

emergency room and then directed to another outpatient department or to his or her personal physician, or, if necessary, admitted as an inpatient.

There may be a problem with uncollected billings in connection with patients treated in the emergency room. The emergent nature of the treatment and the oftentimes overcrowded conditions in the emergency area may not allow for the complete information gathering necessary for proper billing. These receivables may be written off by the hospital. Should the patient voluntarily pay the bill, the payment may not be properly recorded on the books of the hospital.

Emergency room physicians may also be compensated in a variety of ways: salary, percentage of billings or charges, salary plus percentage, or direct billing on a fee-for-service basis.

The outpatient services provided to ambulatory patients vary from hospital to hospital. Teaching hospitals tend to have more specialized clinics (e.g., pediatric, cardiology, dermatology, genetic counseling, arthritis, allergy, cleft palate, low-vision) while community hospitals will have clinics of a more general nature (e.g., gynecology, general medicine, pediatrics, obstetrics).

The outpatient admission may be classified on the basis of emergency, clinic, or referred services depending on patient need for service and the administrative and organizational structure of a facility. The structure of outpatient services will vary (e.g., clinical service units are primarily found in teaching hospitals).

Investigative Steps

(1) Ascertain if patient treatment is being misclassified between emergency and clinic services in order to take advantage of the classification offering the higher reimbursement rate.

(2) Through interviews and visual observations, ascertain if a clinic might actually be in use but not listed on the books and records of the hospital, with the revenue produced being diverted and embezzled.

(3) Determine effectiveness of internal controls or the lack thereof. This could permit the diversion of cash from patients treated in the clinic or emergency areas, whose treatment is not being reported. Also determine if, in the case where treatment is reported, patients who might have

paid cash were listed as indigent or charity cases to avoid recording of payment.

(4) Be alert to over scheduling of patients in the outpatient department which can result in patients leaving before receiving treatment and still being recorded as complete visits. Such visits could later be improperly submitted for reimbursement.

(5) Be alert to multiple treatments being furnished to a patient in the clinic area on a single visit with such treatments being subsequently billed as separate procedures performed on different dates in order to receive a higher reimbursement.

(6) Ascertain if outpatients might be improperly carried as inpatients on a one-day stay basis, thereby qualifying for a higher reimbursement rate.

(7) Ascertain nature and operation of ambulance services for hospital, being alert for ambulance billing for services not rendered. Ambulance services have been known to obtain names of Medicaid patients and their numbers from emergency room logs and schedules and submitting bills for

ambulance services which were never performed. Ascertain if donated ambulances might be carried as purchased vehicles on the hospital books and records.

APPENDIX A

HOSPITAL QUESTIONNAIRE

A. For the period _____ to the present, please provide the following information:

1. Name(s) of administrator(s)
2. Name(s) of controller(s)
3. Name(s) of purchasing agent(s)
4. Name(s) and address(es) of independent accountants retained by the hospital.

B. For the period _____ through _____ please provide the following information:

5. Names and addresses of each vendor and supplier of goods and services of any kind whose annual billings to the hospital exceed $15,000. Give actual amounts of any such vendor's annual billings with a description of goods and services provided. For each vendor, arrange according to category (i.e., drugs, linen, etc.) and then list amount of annual billings for the vendor on a yearly basis.

6. Names and addresses of consultants and description of services performed and amounts of annual billings.

7. Names and addresses of all of the hospital's principals, owners, officers or employees who directly or indirectly participate in the ownership, control, or management of any the hospital's vendors or suppliers.

8. Identify all cooperative buying agreements and arrangements to which the hospital is a party (include name and address of the cooperative and, to extent known, names of the cooperative's principal business officer and names and addresses of other participants).

9. State whether the hospital employs competitive bidding to award contracts for the purchase of goods and services. If so, describe the hospital's bidding procedure. Provide names of hospital employees who control or supervise the bidding procedure.

10. State the percentages of patients whose hospitalization costs were covered by (a) Medicaid, (b) Medicare, (c) private insurers.

11. State whether the hospital provides out-patient services. If so, briefly describe the types of such services.

C. Specify what records and files are computer generated. Does the facility maintain its own computer? If so, what system? If a service bureau is used, please identify.

APPENDIX B

VENDOR'S VOLUNTARY DISCLOSURE LETTER

Date _____

Certified - Return Receipt Requested

Dear _____:

We have been authorized by New York State Attorney General Louis J. Lefkowitz to make an inquiry into the operations of hospitals in the State of New York and the costs of health care financing under the Medicare and Medicaid programs. We have identified your company as a major vendor in the hospital industry. We ask you to cooperate with our office in this investigation and to disclose to us, voluntarily, information concerning sales by your company to hospitals in the State for the calendar years _____ through _____ [five year period], stating:

1.(a) Name and address of each hospital with which your company (as defined below) has transacted business.

(b) General description of goods and services sold to each hospital.

(c) Annual dollar amounts of sales, separately stating allowances, discounts, credits, free goods, rebates, reimbursements, and other reductions in price by off-invoice pricing, deal pricing, or otherwise.

(d) Names and addresses of company representatives, including supervisory personnel, distributors and wholesalers servicing each hospital.

(e) Dates, amounts and sources of all payments (as defined below), together with copies of the front and back of checks evidencing payments made by check, from your company or any person acting as a conduit for such payments to or for the benefit of:

(i) the hospital,

(ii) a member of the board of directors, trustees or governing body of the hospital,

(iii) a hospital employee, agent, independent contractor or other representative,

(iv) a physician, whether or not connected with the hospital,

(v) a member of the family of any person described in (ii)-(iv), and

(vi) a fund, account, bank, person, firm, corporation, entity, institution, or other organization designated by the hospital or a person connected with the hospital.

(vii) Identify the recipient of each such payment by name, address, hospital affiliation, account number, and other particulars.

(f) Any company expense in excess of $50 per item accounted for as advertising, promotion, public relations, research and development, travel and entertainment, or in any other classification, benefitting hospital-based persons, including employees, agents, physicians, independent contractors and any member of their family, showing:

(i) date, amount and description of expense, and

(ii) names and addresses, including hospital affiliations, of the persons benefitted.

(As used in this letter, "company" includes parent, subsidiary, and affiliated corporations, an employee, officer, director or shareholder of the company, and any person acting on behalf of the company as an agent, independent contractor, distributor, wholesaler, or in any other capacity. "Payments" includes cash payments, free goods, payments in kind, the giving of anything of value, and other payments (in cash or in kind) such as advances, commissions, fees, loans, rebates, reimbursements, compensation, contributions, donations, grants, and gratuities.)

2. (a) State whether your company maintains credit cards, charge or similar accounts and whether any individual person described in paragraph 1(e) or any member of the family of any individual person,

person, has used such accounts, or is authorized to do so. If so, identify the accounts and furnish the particulars of all charges made, identifying the persons using or authorized to use the accounts, the items charged, and the amounts of the charges.

(b) State whether your company maintains or pays the expenses of an apartment, hotel suite, club or other accommodation, or automobile, and whether any individual person described in paragraph 1(e) or any member of the family of any individual person has used such accommodation or automobile, or is authorized to do so. If so, identify the accommodation and automobile and furnish the particulars of their use, identifying the persons using or authorized to use such accommodation and automobile and the dates of use.

3. State how the transactions disclosed in response to the foregoing questions are reflected on the company's books and records.

4. Furnish to us a copy of the reports of the findings of your company's internal investigation of questionable payments and transactions.

Your cooperation and prompt response to this letter will be appreciated. If you wish to discuss this matter, please call me at ( ) .

Sincerely yours,

APPENDIX C

GUIDELINES FOR THE ESTABLISHMENT OF A CENTRAL FILING SYSTEM FOR USE IN THE ELIMINATION OF FRAUD, ABUSE AND ERROR IN HEALTH, EDUCATION AND WELFARE PROGRAMS

INTRODUCTION

The primary purpose of the New York Office of the Special Prosecutor's* Central File System is the capability of retrieving information in a timely manner. Properly maintained, the system is a source of valuable intelligence data.

When establishing such a system, the following factors should be considered:

1. how to report the results of an investigation -- should they be set out in a standardized form?

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* The Office of the Special State Prosecutor for Nursing Homes, Health and Social Services is an independent operating arm of the Attorney General that was established by the Governor and the Attorney General on January 10, 1975, to deal with the scandals that had been exposed in the Nursing Home industry in New York State. Since that time, it has been designated the "Medicaid Fraud Control Unit" in New York State. Its jurisdiction has been expanded to include the investigation and prosecution of all Medicaid fraud as well as Private Proprietary Homes for Adults, otherwise known as Domiciliary Care Homes or "Adult Homes". There are seven Regional Offices of OSP.

2. how to store and retrieve the information contained in the reports -- should a Central File Unit be established? -- who would be responsible for its maintenance?

Our Office believes that had not consideration been given to such concerns at the outset of our investigation, our project would have failed. We have found that the advantages of a good standardized reporting system are many and include:

1. establishment of a central repository of intelligence information that assists in ongoing and future investigations

2. capability of a reasonably accurate appraisal of current investigations at any time

3. assistance in reallocating personnel where services are needed

4. ready reference when it becomes necessary to reassign an investigation -- in a logical and orderly manner and with a minimum of time and effort

5. assistance in determining the course of an investigation

6. an effective tool in evaluating the quality of an investigation.

CLASSIFICATION OF INVESTIGATIVE MATTERS

In order to retrieve information efficiently, any mail, both incoming and outgoing, as well as communications and reports is classified by the Central File Unit according to a standard procedure. The Central Office of the Special State Prosecutor (OSP) has established 26 classifications of the types of investigative matter with which it is normally concerned including, for example:

LIAISON
NEWSPAPER CLIPPINGS
NURSING HOME (FRAUD AND LARCENY)
PATIENT ABUSE IN NURSING HOMES
PATIENT ABUSE IN ADULT HOMES
PATIENT ABUSE IN HOSPITALS
ADULT HOMES (FRAUD AND LARCENY)
AND ALL OTHER CATEGORIES OF MEDICAID PROVIDERS

Each classification is assigned a number (e.g., Nursing Homes - Fraud and Larceny is No. 6) to distinguish the type of investigation. Within each classification, a new number is given to each case as it is opened and each piece of mail is serialized sequentially within the number.

For example, each piece of mail going into a New York Region Nursing Home file would be classified in a NY-6 classification; the first Nursing Home investigated would be a 1, and the first piece of mail dealing with that particular Nursing Home would be 1.

> The piece of serialized mail would be read as NY 6-1-1. (If it were a Rochester or Albany Nursing Home File, it would be read as Rochester 6-1-1, or Albany 6-1-1.)

Subsequent mail going into the same Nursing Home file would be placed in date order and be read as:

NY 6-1-2	Rochester 6-1-2	Albany 6-1-2
NY 6-1-3	Rochester 6-1-3	Albany 6-1-3
NY 6-1-4	Rochester 6-1-4	Albany 6-1-4

On the other hand, classification 8 refers to investigation

of Vendors. The New York region mail would read NY 8-1-1; NY 8-1-2; NY 8-1-3 etc., for the first Vendor file opened.

When a Supervisor determines a new investigation is to be conducted, he or she must decide the classification of the case. The Central File Unit then assigns the correct classification number, the case file number in sequence; serial numbers then follow sequentially. Legal size cabinets are used to store the files.

ESTABLISHING THE PERMANENT FILE

Once the Supervisor has determined that a new case file should be opened, the case file must be organized in a uniform manner. The file should include such items as background data, reports of interviews, audit reports, reports from confidential informants, reports on the progress of the investigation, newspaper clippings, and any other information that may have evidentiary value, retrieval value, or provide a lead for further investigation.

INDICES*

In order to achieve the primary purpose of the filing system (that is, the retrieval of information), an indices must be established. OSP has found that the easiest and most effective system is a 3 x 5 card index file, the names on which are filed in strict alphabetical order.

When a case file is established, the principal subject (or subjects) of a specific investigation become the title of the case. Before a case is opened, the title is searched through the indices to insure that a prior case file does not exist. If no previous case file exists, the Supervisor underlines the title on the first piece to go into the file. A blue pencil or pen is used for purposes of prominence. The Central File Unit then prepares a 3 x 5 card. In the upper left-hand corner of the index card, the exact title will be typed in capital letters. One space is left between the title and any identifying data such as addresses, date of birth, employer, etc.

* As of November, 1978, OSP Central Files reflects a record of almost 200,000 individual entities in its Indices.

Directly following the exact title, the month and year in which the case arrived in the Central File Unit is noted.

In the upper right-hand corner of the card, the following is typed:

1. regional code -- territory where the investigation takes place (e.g., New York - N.Y.; Buffalo - BU; etc.)

2. classification # -- category of the investigation

3. file # -- number assigned to each new case in that classification

4. serial # -- number assigned to each new piece of mail

Each serial (i.e., piece of paper, whether mail, memo, report, or the like) to be filed should be marked for indexing -- by underlining in blue pencial all names of individuals, companies, etc. -- of the pertinent information contained therein. The index card would read as follows:

JOHNSTON, WILLIAM J. (MD) 11/78 NY 14-122-32

145 Adams Street
Denver. Colorado

DOB: 11/11/11
SOCIAL SECURITY #: 111-11-1111
Connected with CHILDRENS HOSPITAL

interviewed: 11/11/78

Upon checking the Indices and reviewing the above card, you will note that the New York Regional Office has a record on WILLIAM J. JOHNSTON, MD, of Denver, Colorado, in its Hospital files (14 classification) and that Dr. JOHNSTON is connected with the CHILDRENS HOSPITAL (122nd case opened in the 14 classification) and that his name appears in serial 32 of that file.

When a main case file is opened (CHILDRENS HOSPITAL), the index card will note the file by using an asterisk after the classification and file number. The main case card will appear as follows:

CHILDRENS HOSPITAL 7/78 NY 14-122 *

1515 Main Street
Denver, Colorado

This card indicates, by virtue of the asterisk (*), that a case file has been opened on that particular entity. Once a card is typed for the main subject, it is no longer

necessary to mark the subject for indexing in the main file. However, if the title of the main file is changed, a new card will reflect this by typing the name of the new subject and again the asterisk is used.

Once the indexing is completed on a serial, a red "slash mark" is drawn through every blue underline indicating that an index card has been prepared. Some serials may have only one name underlined in blue, others may have 15 or 20; it all depends on the nature of the serial to be indexed. As the cards grow in number and are filed alphabetically, they will be the only means of ascertaining the location of the information in each file.

RETRIEVING INFORMATION

Each case file is placed in numerical sequence within the specified classification. In retrieving material on a particular investigation, OSP staff proceed to the files, pulling that section containing the serial number obtained from the index card for the desired information. If it becomes necessary to remove a file from the Central File Unit, it is done by means of a charge-out card, listing the file number in its entirety, including the last serial # in the file, and signed in the name of the

person taking the file and the date taken. This charge-out card is placed where the file is permanently located. Files should always be locatable and OSP requests that all files be returned within five days.

EXHIBITS

Exhibits are those documents, items of evidence, and the like which are pertinent to an investigation. The Central File Unit is the logical place for such documents to be filed. The size and value of the exhibit determine the place where the exhibit should be filed. If an exhibit is of such size that it can be filed in the investigative file, it should be placed in a letter-size manila envelope, referred to as 1A Exhibit, and placed in the first section of the file under serial #1. Each exhibit in the 1A category is placed in a white envelope showing the file number, cross-referenced to the serial submitting the exhibit, date received by investigating employee, name and address of contributor, name of employee receiving the 1A Exhibit, whether or not it may be returned, and a description of the exhibit. Identical data describing each exhibit is typed on the manila envelope.

When a exhibit is too large or bulky to be placed in the 1A Exhibit manila folder, it should be referred to as a

1B Exhibit and placed in a red-rope envelope and stored in a secure locked cabinet or storeroom. In these cases, a white envelope is made up, containing the same information as in the 1A Exhibit, and filed in the investigative file.

Only authorized OSP staff can charge out either the 1A or 1B type exhibits, again by use of a charge-out card which is then filed as the top serial in the last section of the investigative file. A colored sheet showing the contents of the red-rope envelope is affixed to the outside of the red-rope envelope; a duplicate of the colored sheet is placed on the top of a 1A manila envelope in the first section of the file.

RESPONSIBILITY

The Central File Unit has the responsibility for the orderly receipt, processing and control of all mail, complaints, memoranda, investigative reports, auditor reports, and any related documentary evidence generated during the course of the investigation. File must be updated daily and the index cards alphabetized and filed as quickly as possible. All cards should be filed within the week. No file should ever be in a "lost status" and to prevent this from happening, a weekly check of

charged-out files should be made to ascertain the person working on the file while it is out of the Unit. A physical check of the charged-out file should be made, by ascertaining that the employee still has the file charged to him/her and by reflecting new charge-out dates and names.

COMMENT

Though not an easy task, the system as described above, if properly implemented and administered, will go a long way toward increasing the effectiveness of fraud, abuse and error control. Attention must be given to proper supervision in order to achieve what we believe to be a simple, but elastic, system. Though OSP uses this system in the investigation and prosecution of Medicaid fraud and abuse, we believe this can be adapted to any investigaiton of fraud, abuse or error.

PREPARATION OF SP-2'S

I. Definition of an SP-2*

A written report prepared by an investigator setting forth the results of an interview with a person furnishing information which may become testimony.

II. Reason SP-2's are prepared

SP-2 interview forms can be furnished to a defense attorney under the rules of discovery. The SP-2 forms can easily be extracted from a report, making it possible to furnish to the defense attorney only the results of investigation that the attorney is entitled to receive.

III. What are the three classifications or types of information which may become testimony

a) Signed or unsigned statements of a subject or witness;

b) Relevant information not in a signed statement furnished by a subject or potential witness - this information is reported on an SP-2;

*Special Prosecutor's Form-See last page of Appendix C.

c) Information developed by the investigator which may become the subject matter of testimony and introduced or presented in court by the investigator - this information is reported on an SP-2.

Example:

Reporting the results of record check, physical observations, etc.

Comment:

Key to the need to prepare signed statement or SP-2 is that information should be relevant to matter being investigated. No other information should be placed in SP-2. If person interviewed furnishes additional information not relevant to matter being investigated, this information can be recorded in a memorandum in another SP-2 if appropriate.

IV. Only one interview per SP-2 form

Example:

Husband and wife interviewed together and give same information - prepare two SP-2 forms.

Comment:

If subject or witness gives information about more than one event, prepare as many SP-2 forms as necessary.

V. Always (with the exception of informant information) include name, address or other identifying data in the first paragraph of the SP-2 of the person interviewed.

Comment:

If a person interviewed is considered as a potential key witness, try to obtain as much identifying data as possible about person. This will make it much easier to locate person later if he moves or changes jobs. The additional identifying data about the person can be included in the cover memo prepared along with the SP-2 form.

VI. Where applicable, report information on SP-2 in a narrative form - it is assumed the information was obtained by the investigator preparing the SP-2 unless so stated.

VII. Dictate SP-2's within five working days. Attempt to have transcribed within five working days from date of dictation.

Vlll. After SP-2 is transcribed and approved by investigator, the investigator should initial original copy at which time he may destroy his notes, unless specifically instructed not to do so by prosecutor.

IX. The original copy of SP-2 should never be marked for indexing or any other notations placed thereon including file numbers. A cover channelization memo should be prepared and original SP-2 form should be filed in main case file.

If it is necessary to index SP-2 form, an extra copy should be prepared for file and this copy marked for indexing by drawing a blue line under names to be indexed.

Comment:

When identifying data is available along with the name to be indexed, this identifying data should be also underlined and included on index card.

X. Reporting information received from confidential informants on SP-2 forms

When investigator dictates, he should instruct steno to leave blank space where the name of the person furnishing the information would normally appear on the original copy of the SP-2. The investigator should thereafter refer to this person in the SP-2 as the "confidential source".

After the investigator has approved the typed copy of the SP-2, he should have the confidential informant's name typed on the original copy only. All other copies of the SP-2, the steno will type in this blank space wording such as "a confidential source advised..."

The original copy of the SP-2 containing the informant's name will be filed in the informant's confidential file.

When a report is prepared containing information received from a confidential informant, the confidential informant will be identified by symbol number in the administrative section of the report.

XI. Channelization of SP-2's

1. Original copy after initialling is to be sent by cover memo to central files;

2. If indexing of SP-2 is necessary, prepare extra copy and mark for indexing and send to central files;

3. Copy of all SP-2's are to be sent to attorney responsible for prosecution of case;

4. Investigator should hold extra copy of SP-2 for inclusion at time he prepares next investigative report.

XII. Investigator should never include his opinion as to the reliability of subject or witness in details of SP-2. A subject or witness can be <u>described</u> in details of SP-2 but never should investigator set out his opinion.

If investigator thinks it is appropriate, he can comment about the subject or witness in the cover memo to the SP-2 and set out this same information in the administrative section of the report.

XIII. Summary

SP-2's should be:

1. Accurate - report facts as facts, heresay as heresay;

2. Completeness - narrate all facts discovered during the course of the investigation;

3. Brevity - this is achieved by keeping out all unnecessary detail;

4. Impartial - report all facts both favorable and unfavorable to the prosecution without any additions or subtractions by writer;

5. Form - arrange contents in a manner reader can readily understand about the matter being reported.

SPECIAL PROSECUTOR

Date _____ (Date of Transcription)

(by Typist)

SAMPLE OF FORM USED BY OFFICE OF THE SPECIAL PROSECUTOR TO RECORD INTERVIEWS WHICH MAY BECOME SUBJECT OF TESTIMONY AT TRIAL.

On (Date of Interview) at (City and State where Interview Conducted) File # (Agency File Number)

by (Identity of Investigator or Investigators Conducting Interview). Date dictated (Date Investigator Dictated Results of Interview).

APPENDIX D

GOODS AND SERVICES PURCHASED BY HOSPITALS

Acoustical Materials
Addressing Machines and Supplies
Administrative Sets; Blood and Solution
Administrative Services
Aerators
Air Conditioning Equipment
Air Fresheners
Air Instruments
Air Washers
Alarms and Alarm Systems
Ambulation Devices
Analysis Units; Clinical Testing
Anesthesia Apparatus and Products
Apparel and Garments; Disposable,
    Patient, Personnel
Applicators; Antiseptic, Unit Dose
Appraisal Service
Aprons
Arm Boards
Aspirators
Audiometers
Audiovisual Equipment
Autopsy Room Equipment
Back Rests
Bags; Autoclaving, Bedside, Laundry, Plastic
Bandages
Baskets; Canvas, Plastic, Wire
Bassinets
Bathroom Accessories
Baths; Hydrotherapy, Paraffin, Sitz
Bedpans
Beds
Bidets
Blades; Surgical
Blood Analysis Equipment
Blood Collection Equipment
Blood Derivatives
Blood Pressure Apparatus
Body and Limb Holders
Boilers; Steam
Book Publishers

Bottles
Boxes
Bronchoscopes
Brushes
Bulbs
Bulletin Boards
Bumpers; Foam, Rubber
Business Office Systems
Cabinets and Case Work
Calculators
Cameras
Cannulas
Caps
Carafes
Cardiac Arrest Equipment
Cards; Medication and Diet; Plastic
Carpet Cleaning Equipment
Carriers; Crash Carts, Food, Surgical Care,
    Central Supply
Cassettes
Casters and Wheels
Cast Materials
Catheters
Centrifuges
Chair-beds
Chairs
Chart Holders
Chemicals and Reagents
Chromatographs
Chutes; Linen and Waste
Clamps
Cleaners and Detergents
Clincial Laboratory Information Systems
Clocks
Collection Units
Collectors
Colostomy Appliances
Colposcopes
Commodes
Compactors
Computers
Connectors
Construction Management
Construction Design
Consultants; Clinical and Medical,
    Construction and design, financial,
    hospital systems, housekeeping, laboratory,
    labor management, laundry and linen,
    general management, physical therapy,
    planning, project management safety
Containers
Controls; Door, Automatic, Photoelectric
    Sterilization

Conveyors; Food Service, Laundry, Pharmacy,
    Pneumatic Tube
Cookers
Corner Guards
Cotton; Surgical
Covers; Matress, Pillow, Plastic,
    Antibacterial
Covers; Shoe, Conductive
Cribs
Crib Tops
Crutches and Canes
Cubicles
Cushions and Curtains
Data Processing Equipment and Systems
Decontaminents
Defibrillators
Dental Equipment and Supplies
Deodorants
Dermatomes
Detectors; Electrical Current Leakage, Grounds,
    Radiation, Smoke.
Dialysis
Diapers
Diathermy Apparatus
Dictating Equipment and Services
Dietary Department Equipment & Supplies
Dishes; Food Service, China, Paper, Plastic,
    Disposable
Disinfectants
Dispensors
Disposers
Dividers
Doors
Douche
Drainage Systems; Urinary
Drains; Postoperative
Draperies; Patient, Surgical, Obstetrical
Drawsheets
Dressers and Chests
Dressings and Bandages
Drills; Bone, Dental
Drugs and Pharmaceuticals
Dry Cleaning Equipment
Dryers
Dumbwaiters
Echocardiographic Systems and Supplies
Echoencephalograph Supplies
Electrical Fittings and Fixtures
Electrocardiograms and Supplies
Electromyographs

Electrical Protection Equipment
Electrosurgical Apparatus & Accessories
Elevators
Enema Administration Units
Engineering
Engraving Equipment
Entrance Control Devices
Environmental Control
Escalators
Exhaust Systems
Extinguishers
Fans
Faucets and Fittings
Film; Motion Picture, Badge Service, X-Ray
Filters
Finger and Foot Printing Equipment
Fire Door Release
Flag Poles
Flash Lights
Floor and Wall Cleaners
Floor Coverings
Floor Maintenance Machines
Floor Mopping
Floors and Flooring Material
Flowmeters
Fogging Equipment; Room
Folding Machines
Food
Food Service Equipment
Food Boards
Forms; Business Office, Medical Records, Medication
Formulas; Infant and Pediatric
Freezers; Blood, Bone, Eye Bank
Food Processing
Fund Raising
Furniture
Gasses; Medical, Sterilizing
Gift Shop Supplies and Equipment
Gloves; Cotton, Disposable, Examination Household, Surgical, Utility.
Grounding Jacks and Plus
Hampers; Fabrics, Metal, Plastic
Handrails
Hardware
Heaters
Holders; Card, Bed, Door, Chart
Hoods; Fume
Housekeeping Department
Management Services
Housekeeping Service

Humidifiers
Hydrotherapy Concentrate Solution
and Equipment
Hypothermia Equipment
Ice Bags
Ice Making and Storage
Identification Cards
Identification Systems
Ileostomy Appliances
Implants
Incinerators
Incubators
Information Retrieval Systems
Infusion Systems
Inhalation Therapy Equipment and Services
Inks
Instrument Repair Service
Instruments; Clincal, Diagnostic,
Electrosurgical, Obstetrical and
Gynecological, Orthopedic, Surgical
Intensive Care Units
Intercommunication Equipment
Interior Design Service
Intermittent Compression Equipment
Intravenous Sets and Supplies
Inventory Control Systems
Ironers
Irrigators
Isolation Systems
Kettles
Key Control Systems
Kits; Maternity Care, Patient Admission,
Surgical, Suture Removal
Labels
Lab Equipment and Supplies
Ladders
Lamps
Lasers
Laundry Equipment and Supplies
Lavatories
Leasing; Capital Equipment
Lifts; Bed, Patient, Hydraulic
Light Control
Lighting Fixtures
Lighting; Emergency, Examination, Flood/
Spot, Fluorescent, Incandescent
Linen Supplies and Service
Lint Collectors
Lockers
Lubricants
Magnifiers
Mail Handling Equipment

Management Services
Marking Equipment
Masks; Surgical, Disposable
Massage Equipment
Mats and Matting
Matresses
Medical Information Systems
Medical Records
Medical Transcriptions
Mending Equipment and Supplies
Microfilm Services and Sales
Microscopes
Modular Wall Systems
Monitoring Equipment
Morgues; Portable
Name Tapes
Napkins; Sanitary
Nebulizers
Needles; Hypodermic; Radiology, Spinal, Surgical
Nurse Call Systems
Nursing Management Consultant
Occupational Therapy Equipment and Supplies
Operating Room Equipment and Supplies
Opthalmoscopes
Orthopedic Equipment and Supplies
Oscilloscopes
Ovens
Oxygen Administration Equipment
Pacemakers
Packs; Obstetrical, Disposable, Surgical
Pads; Bed and Furniture, Breast, Chair,
    Maternity
Paging Systems
Paper; Food Service
Parking and Traffic Consultants
Parking Lot Equipment
Partitions; Folding and Movable
Patient Charting Systems
Patient Isolators
Pens
Personnel Record Systems
Pharmacy Department Equipment
Photocopy Machines
Photographic Equipment and Supplies
Physical Therapy Equipment
Pillows
Plant Operations Management
PLasters; Cast Material
Plasticware; Laboratory
Plugs and Connectors

Plumbing Fittings and Fixtures
Power Supply Cords
Pressers; Apparel, Trouser
Proctoscopes
Projectors
Property Control systems
Protectors; Corner; Door Frame; Elbow and Heel
Public Relations Aids
Pulmonary Function Equipment
Pumps; Breast, Infusion, Surgical, Temperature
Purifiers; Air
Racks; Bicycle Chart, Clothing, Dishwashing, Storage, Utensil
Radio Equipment
Radiology Equipment and Supplies
Rail Systems
Razors and Razor Blades
Receptacles
Recruitment Service; Executive
Refrigerators and Freezers
Regulators; Oxygen Flow
Rehabilitation Equipment & Supplies
Respiration and Resuscitation Equipment
Respiratory Therapy Services
Restraints; Patient
Safes
Safety Audits
Saws; Bone
Scales; Patient, Bed Weighing, Patient Chair Weighing, Infant, Laboratory and Pharmacy
Scalpels
Scanners
Scintillation Counters
Screens
Scrub Suits
Security Service
Serums
Sheeting
Shelving
Shielding
Shoes and Footware
Showers
Shrouds
Shutters
Signal Lighting Systems
Sign Making Machines
Signs; Desk, Door, Bed
Silver Recovery from X-Rays
Sinks; Laboratory, Surgical
Slides; Medical, Nursing, Teaching

Slippers
Soaps
Solutions
Spirometers
Splints
Sponges
Sprays
Standby Electrical Systems
Stands; Intravenous
Sterile Packaging
Sterilizers
Stethoscopes
Stools; Adjustable
Stretchers
Suction and Irrigating Apparatus
Sutures and Ligatures
Swabs
Switchboards
Syringes
Tables
Tapes; Adhesive, Labeling, Linen
Telephone Systems
Television; Equipment and Supplies; Closed Circuit Systems
Tents; Oxygen, Humidity
Testing Kits
Thermometers
Timers; Electrical
Tissue Culture Apparatus
Tonometers
Tourniquets
Towels
Tracheostomy Care Sets
Traction Apparatus
Training Programs
Transformers
Trash and Linen Systems
Trays; Food Service, Medical & Surgical
Tubes and Tubing
Ultrasonic Diagnostic Equipment
Underpads
Ureterostomy Appliances
Urinals
Urine Measurement Devices
Vacuum Cleaners
Valves and Fittings
Ventilators
Viewers
Wall Coverings
Warmers
Washing Machines and Dryers

Washers; Bedpan, Garbage Can, Glass and Bottles, Hair, Laboratory, Laundry, Pot and Pan, Wall
Washroom Acessories
Waste Disposal Systems
Water Conditioning Systems
Window Glass
Wiring Devices
Wrapping Material
X-Ray Supplies and Equipment

APPENDIX E

INVESTIGATIVE INTERVIEWS

An interview is a planned and purposeful attempt by an investigator to elicit information from individuals who may have knowledge, directly or indirectly, of events, persons, or circumstances concerning a matter under investigation.

Interviewing is one of the most important investigative tools in the detection and investigation of white collar crime. The interview often makes the difference between success or failure in a case. This is a skill which is developed usually only after years of experience in the investigative field. There are certain basic steps which must be utilized by the investigator in developing the skill of conducting an effective interview.

The purpose of an interview is to:

(a) Gather hitherto unknown facts,

(b) Obtain or develop hearsay information regarding matters under investigation,

(c) Develop information to establish elements of

a violation of law or abuses within the industry,

(d) Obtain information which could provide leads in developing the case,

(e) Secure the cooperation of the witness or a potential witness,

(f) Obtain admissions and confessions from suspects,

(g) Recruit other witnesses, confidential sources, and informants,

(h) Obtain, identify, and explain documents and physical evidence, and

(i) Ascertain complete background of the witness, including motives for furnishing the information.

The type of investigation associated with hospitals involves interviewing individuals who may be outstanding members of the business community. This requires the investigator to make a good appearance. An investigator

who is well groomed enhances the prestige of the office he or she represents. The properly attired investigator creates a favorable atmosphere which facilitates the giving of information by witnesses or suspects.

The investigator must always maintain a professional attitude, regardless of the witness's or suspect's station in life or standing in the community. The investigator must be prepared to maintain the proper emotional attitude and balance during the interview. The investigator should be flexible in his or her attitude toward the witness or suspect, not only in arranging for the interview, but also during the interview itself. Objectivity is the key in conducting a proper interview to elicit information. The language used in an interview should be selected carefully. The investigator should use language which is easily understandable and which will not offend or alienate the witness or suspect. There should not be an air of superiority or arrogance in the investigator's manner or tone. The investigator's demeanor should convey confidence and trustworthiness.

Individuals who can be interviewed during the course of an investigation fall into one or more of the following categories:

--Complainant

--Witness

--Suspect

--Potential subject or defendant

--Informant

--Others (e.g., heads of agencies, custodians of records)

The motive(s) each person may have in providing--or withholding--information should always be ascertained by the investigator, prior to the interview, if possible.

During the course of a hospital investigation, there are many individuals who are in a position to provide information that may assist the investigator. These individuals include the following: members of the governing board, administrator, medical staff, business office personnel, nursing staff, maintenance personnel, patients, vendors and governmental officials.

Planning and Preparation for Interview

There is no substitute for the investigator doing his or her homework prior to conducting an interview. This means all available information, including records and

reports relating to the individual's background (such as job responsibilities) must be reviewed and understood prior to the interview. The individual's relationship to others involved in the investigation should be thoroughly explored and understood prior to the interview. Proper planning will result in a successful interview and greatly enhance the success of the total investigation. Lack of preparation by the investigator prior to the interview may result in a poor interview and even cause irreparable damage to the investigation. The subject of the interview may conclude from the investigator's lack of preparation that the caliber of the investigator and the office he or she represents is mediocre. This type of conduct by the investigator may discourage the subject from furnishing information and may even cause the subject to furnish false information or leads. The investigator must realize that he or she is cloaked not only with the authority, but also the prestige of the office which he or she represents.

The number of investigators conducting the interview of a witness is generally dictated by the role and importance of the person to be interviewed in the case. For example, the gathering of background data from public and private sources may only require one investigator. The interview of a witness who may be

vital in giving testimony concerning the involvement of a suspect may require two investigators. At all times, every suspect should be interviewed by at least two investigators.

Generally, in the more complicated interviews, aspects of which might involve highly technical matters, it is advisable to formulate and reduce to writing the questions that are to be asked of the subject in advance of the interview. Formulating and writing the questions in advance enables the investigator to adhere to a specific plan for conducting the interview, in order that complete and accurate information can be obtained. The following ideas are put forth as a suggested guideline for the investigator in formulating an interview plan.

(1) In the beginning of the interview, questions should be posed which elicit general background information concerning the witness. Asked properly, these questions and answers should lay the foundation for the more critical and difficult questions to follow.

(2) The questions should be concise, and should be put to the witness one at a time.

(3) The questions should be comprised of easily understood words and well established meanings.

(4) An organized outline of questions should be prepared prior to the interview and they should be followed during the interview. The questions should be organized around time sequence, locale, etc. The interviewer should not skip back and forth since that will tend to discourage full development of important details.

(5) The questions should be conversational as opposed to ritualistic. The interviewer should allow time for the witness to elaborate on his answers and volunteer details.

(6) The questions and answers at an interview are the only means of communicating the thoughts, knowledge, experience, and feelings from the witness to the interviewer. Therefore, great care should be given each question. Each answer should be weighed carefully and understood by the investigator before posing the next question. At times, a witness's answer might be subject to different interpretations, and this should be clarified. As noted, it is advisable to have at

least two investigators present so that the interview is as complete as possible.

Following the preparation of a plan for the interview, thought should be given to scheduling the best time for the interview. This may be done by communicating with the person to be interviewed by telephone to arrange for an appointment. The telephone provides the most expeditious means to establish contact for the purpose of making an appointment. Face-to-face contact in arranging for an interview may not be desirable because the subject may attempt to have the interview conducted immediately at a time and place that may not provide the best setting to the investigator. Arrangements for an interview should include adequate time, taking into account not only the subject matter that is to be discussed, but any additional factors or events pertinent to the investigation that may be a source for additional discussion during the interview. Sufficient time should be scheduled so that a complete interview can be conducted. It is the better practice to allow for extra time in the event the witness brings up additional topics that you may want to explore with him. The momentum the investigator obtains during an interview is vital and should not be curtailed by tight scheduling. The investigator may not be afforded a

second opportunity to interview the witness or suspect; therefore, sufficient time is a must.

On occasion there are advantages to interviewing witnesses or suspects at the investigator's office, and at other times there are advantages in conducting the interview at the subject's residence or place of business. The advantages of the investigator's office are: the investigator should be able to maintain complete control of the interview; the office is an environment free from distractions; and the office atmosphere allows the subject to talk more freely. This type of setting also enables the investigator to <u>listen</u> attentively and with greater concentration on the subject matter being discussed. Conducting interviews at the subject's home or place of business may allow immediate access to records or documents which ordinarily would not be available at any other place. The subject may be more likely to furnish the investigator with documents on the first request at home or place of business, due to their proximity. If the subject has further time to reflect on this request, or to discuss this request with others, the subject may decide not to voluntarily furnish such documents. If the subject is given time to produce such records the possibility exists that there may be alterations or destruction of the records to be produced.

During the course of an investigation, the time of scheduling of an interview can be critical. The involvement of a subject in the case under investigation will dictate at what point in the investigation they will be interviewed. For example, during the initial stage of an investigation it would be logical to interview the individuals, public and private, who possess background data and other related information regarding the subject matter under investigation.

Suspects can be interviewed in the final stages of an investigation, after all the information and fact gathering has been completed.

The initial contact between the subject and the interviewer in the first few minutes of the interview will usually determine the tenor for the entire session. The interviewer should try to put the witness at ease by being polite but firm. The interviewer should give the witness an insight into the reasons for being interviewed. The investigator should give the witness a complete opportunity to answer questions without interruption. The investigator should make a mental note of any inconsistencies in the responses of the witness and any other matters which might require

clarification. It is also advisable that the interviewer listen and not take any notes until the appropriate place in the interview. Note-taking while the subject is speaking may be a distraction, making the subject lose his or her train of thought.

After the subject has gone through a complete narration of the facts, the interviewer should have the subject repeat the story, and, after the subject does so, the interviewer should begin taking notes. As the investigator takes notes, he or she should review the narrative with the subject and question him or her to clarify any points which remain unclear.

At all times, the interviewer should maintain absolute control of the interview. If the subject rambles, he or she must be brought back to the subject matter of the interview, otherwise, the subject may venture into areas which are irrelevant, thereby wasting the investigator's time.

At the close of the interview, the investigator should seek to obtain original documents, such as cancelled checks, receipts, brochures, sales literature, prospectuses, warranties, guarantees, letters, envelopes, contracts, et cet., and should give a receipt for all items. The investigator should initial and date

the back of each page of the documents in order to preserve the chain of evidence.

If an admission or confession is made during an interview, the investigator should reduce the admission or confession to a written statement signed by the subject.

At the conclusion of the interview, the subject should be made to understand that, in the event that additional information is needed, the subject will make himself or herself available for further interview. Also, the subject should be told that, if additional information comes to the subject's attention, he or she should communicate with the investigator in order to furnish such additional information. The person should be instructed that, if he or she is contacted about the interview, other than by the subject's attorney, he or she should forthwith contact the investigator.

Interrogating a Suspect

The object of interrogating a suspect is to obtain information concerning his or her involvement in the matter under investigation and if possible, to obtain an

admission of, or confession to a violation of law. Additionally, the investigator should attempt to ascertain the existence and location of any physical evidence which the suspect might have or any information implicating others in the commission of a crime. At the outset of an interview, it is of paramount importance that the investigator immediately advise the suspect of his or her constitutional rights.

Oftentimes, a suspect or counsel, or both, may request an interview or meeting for several reasons:

(1) The suspect may be motivated by a desire to clear up the situation;

(2) The suspect may wish to influence the investigator; or

(3) The suspect may want to learn how much the government knows.

Whatever the reasons for which the suspect requests an interview, the investigator is in a favorable position to get the suspect to talk about his or her business. In so doing, the suspect may help the investigator in establishing some, if not all, of the elements of a violation of law.

If the investigator requests an interview of the suspect, the investigator should be extremely well prepared and alert to non-responsive or misleading answers, and the probability that the suspect will impart lack of knowledge, or try to evade the questions.

Note-Taking During Interview

The taking of notes is a means of enabling the investigator to make a record of the substance of the interview. Immediately following an interview, the investigator should review his or her notes and clarify them where necessary. If it becomes necessary, the subject should be contacted to clarify any statements that are unclear.

As noted, it is important to have two investigators present at some interviews in order to have a structured pattern of questioning, with a complete and accurate report of all important facts and events.

The types of material developed from interviewing subjects which should be retained are:

(1) Written statements, signed by the witness, if possible;

(2) Written statements, unsigned by the witness, but approved or adopted in any manner by the witness;

(3) Notes which are a substantially verbatim recital of an oral statement by the witness. This covers shorthand, speedwriting, or longhand notes, as long as they are substantially verbatim and complete in recording what the witness said on interview; and

(4) Notes which have been read back to the witness or which the witness has been allowed to read, and which have been approved or adopted by the witness as his account of the matters concerning which he is interviewed.

Following the conclusion of an interview, the investigator should, within a reasonable period of time (usually five days), dictate a report to a stenographer from the investigative notes. After the stenographer transcribes the results of the interview in report form, the investigator should compare the transcribed interview with his or her notes and recollection of the interview. The report becomes the final work piece of

the investigator, setting forth the results of the interview of the witness or suspect. The report of the interviewer, prepared by the investigator, should be maintained and preserved for utilization by the prosecutor, and should be a reference in providing the investigator with additional leads.

It is also wise to recall that if the subject goes to trial, the investigator's report of the interview will be given to the defense counsel and the investigator may be questioned on the witness stand regarding the contents of the report.

The results of all interviews of witnesses and suspects conducted by the investigator should be made available to all members of the investigative unit. It is advisable to remember, during the course of an investigation, it is better to have everyone in the unit aware of the results of every interview as the investigation progresses, so that periodic discussions and evaluations of the information may be made by the members. This team approach will engender a more efficient and thorough development of the case.

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